Arizona Rural Hospital Facilities and Market Study 2008

Sponsored by the Arizona Health Facilities Authority

This report was prepared by Health Solutions and Market Intelligence in collaboration with the Rural Health Office, The University of Arizona Mel and Enid Zuckerman College of Public Health

Arizona is the second largest growing state in America. Population growth heavily impacts health facilities planning. This report provides useful market information affecting facility expansion planning for the state's rural communities.

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Acknowledgements

We would like to extend appreciation to the Board Members of the Arizona Health Facilities Authority (AHFA) for supporting this Arizona rural hospital facilities study. Arizona's population growth over the past decade has drawn attention to the need for examining the extent to which existing rural hospital structures not only meet patient needs and demands but also regulatory requirements for patient safety. The AHFA Board realized the importance of gaining a deeper understanding of rural hospital capacity in Arizona, a vision that led to collaboration between the Rural Health Office at The University of Arizona, Mel and Enid Zuckerman College of Public Health (MEZCOPH), and Health Solutions and Market Intelligence, a healthcare management consulting firm located in Arizona whose staff members completed the research and study analysis. Mr. Mike Albertson of Health Solutions and Market Intelligence (HSMI) served as the subcontractor for this report. He contributed most of the work that resulted in the data and projections made in this report. His efforts are appreciated.

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EXECUTIVE SUMMARY

The Arizona Health Facilities Authority (AHFA) was established by the Arizona State legislature in 1977 to issue bonds for the purpose of improving health care for residents of Arizona by providing less expensive financing for health care facilities. In 2007, the AHFA board members sought up-to-date information about the impact of Arizona's growing population on the need for health facilities renovation and expansion. AHFA contracted with the Rural Health Office (RHO) at The University of Arizona Mel and Enid Zuckerman College of Public Health to facilitate the completion of this study. The RHO subcontracted with Health Solutions and Market Intelligence (HSMI), a healthcare management consulting firm, to implement the study details.

The purpose of the study was to identify the issues affecting rural hospital development in Arizona. The issues examined included strategic planning, facility development, financial/capital position, human resource/workforce challenges, community leadership support, and the adoption of health information technology applications.

It is important to note that the data presented in this report were aggregated so as to preserve the anonymity of the participating hospitals. A great deal of information shared by the hospitals was proprietary and used only insofar as it could contribute to a balanced and fair report that preserves confidentiality.

The study was undertaken in three phases:

1. Define markets and population growth by geographic region
2. Categorize hospitals and trend performance utilization and provide a financial ratio analysis
3. Conduct hospital management surveys

Hospitals were divided into four groups:

1. Indian Health Service Hospitals and Tribally-operated Hospitals (Including CAHs)
2. Small/Critical Access Hospitals (<25 census)
3. Rural Hospitals (25<50 census)
4. Regional Hospitals (>50 census)

The study methodology is described, along with an analysis of the findings. These focus on market growth and demand, financial performance profiles of the targeted hospitals, aggregated responses from hospital administrators to a comprehensive survey,

hospital strategic planning implementation and facility development plans, community/ leadership support for rural hospitals, financial/capital issues, human resource/rural workforce challenges, and technology adoption.

The summary and conclusions presented in the study were drawn from the survey responses and personal interviews conducted by Health Solutions and Market Intelligence (HSMI).

An important finding in the study may be found in the section Market Growth and Demand. HSMI projects that between 2008 and 2013 there will be a need for 289 acute care, medical/surgical beds in rural Arizona to serve new populations, and also a need for 227 physicians to serve the growing demand for health care services.

The following recommendations are made based on the study conclusions.

1. The Arizona Health Facilities Authority should support replacement facilities or renovation projects for the state's Small/Critical Access Hospitals, including those operated by IHS and tribal-affiliated organizations. Such support should consider the important role these hospitals play in delivering care to rural people, as well as the importance of the economic impact they have in their communities. Financial viability and market growth should not be the major drivers behind support for facility replacement or renovation projects.

2. Community leaders should urge and support *à la carte* financing opportunities for Small/Critical Access Hospitals, including those operated by the Indian Health Service (IHS) and tribal-affiliated organizations, to renovate, rebuild or replace their facilities in order to meet the growing population demand for services.

3. The Arizona State Legislature should authorize a technical assistance program for Critical Access Hospitals that need new facilities, to assist them with feasibility studies, planning and architectural assistance.

4. The Arizona State Legislature should examine new methods for providing incentives to physicians and nurses willing to practice in Arizona's high shortage rural and frontier areas, including Native American communities.

5. The Arizona State Legislature should **increase** the funding pool for Critical Access Hospitals, proportionate with the increasing number of Rural Hospitals that receive Critical Access designation.

6. The Arizona State Legislature should continue to appropriate funds for the Stable, Accessible, Viable and Efficient (SAVE) pool discussed in this report in order that the eligible Critical Access and Rural Hospitals can remain viable and build new facilities, as needed.

7. Arizona's Congressional delegation should provide leadership in urging Congress to increase Congressional appropriations for the Indian Health Service facility capital budget, and members of the Arizona State Legislature should voice support for such an increase to the Congressional delegation.

8. Programs should be generated by public and private sector agencies that provide mechanisms to recruit and retain health care providers and hospital executives willing to work in rural Arizona.

9. The Arizona State Legislature should increase the funding appropriation designated for the Rural Health Office at The University of Arizona Mel an Enid Zuckerman College of Public Health, with an explicit mandate that this office direct these resources to improve access to care and increase the viability of the most vulnerable rural hospitals.

10. National and state health care reimbursement mechanisms should provide incentives for Rural Hospitals to implement health information technology applications, and to access telemedicine technology and e-prescribing technology.

11. Municipalities, tribal governments, and local Chambers of Commerce should recognize, acknowledge, and support the small hospitals serving their communities, and the importance of the economic impact these hospitals have on the local economy by budgeting funds to support the planning and development of hospitals and medical services in their communities.

12. Recognizing that strategic planning is integral to Rural Hospital survival, hospital administrators should conduct short- and long-term strategic plans, and routinely monitor their progress of such plans, and use the plans as pathways to the future.

13. The Indian Health Service should adopt a policy that urges Rural Hospitals under its jurisdiction to regularly review and update their strategic plans, and to use the plans as pathways to the future.

14. The Indian Health Service should establish a formal procedure for eligible IHS Critical Access Hospitals to apply to CMS for swing bed services in order that they can better meet the needs of their elderly patients.

15. A state-wide study is needed of the economic impact of Arizona's rural health care systems on the health of county and state economies.

16. An ongoing communications and information dissemination system is needed to inform members of the Arizona State Legislature and Arizona's Congressional delegation about the status of the health care systems serving their communities.

17. Arizona's Rural Hospitals and Critical Access Hospitals should collaborate in the design and implementation of activities that focus on hospital finance and workforce development.

STUDY PURPOSE, METHODS AND RESULTS

Purpose of the Study

In 2007, The University of Arizona, Mel and Enid Zuckerman College of Public Health, Rural Health Office (RHO), with the support of the Arizona Health Facilities Authority (AHFA) undertook an ambitious study to identify the issues affecting rural hospital facility development in Arizona.

This comprehensive study resulted in the participation of 100 percent of the 34 targeted rural hospitals including those managed by the Indian Health Service (IHS) and two by Arizona Indian nations.

The study identifies issues related to strategic planning/facility development, financial/capital position, human resource/workforce challenges, community leadership/support, and technology adoption.

To implement the study, an Arizona based healthcare management consulting firm, Health Solutions and Market Intelligence (HSMI), was retained to provide the data and analysis and to summarize study findings. To oversee the study, an Advisory Committee was formed consisting of representatives from the RHO, AHFA, HSMI, IHS, and the Arizona Department of Health Services (ADHS). The Rural Health Office supervised the study, generated the active involvement of Indian Health Service personnel, edited the final report, and prepared recommendations based on information provided.

Recommendations that evolved from the study results were developed by the Rural Health Office project staff in collaboration with HSMI, and do not represent the views of the Advisory Committee, most of whom are employed by federal or state agencies.

Methodology

The study comprised three components: define markets and population growth; categorize hospitals and trend performance and utilization; and, conduct hospital management surveys. The following describes the approach for each component:

Define Markets and Population Growth

Health Solutions and Market Intelligence initiated the study with a geographic breakout and analysis of 31 rural healthcare regions throughout Arizona (see Appendix A). These regions were defined by contiguous zip code boundaries having one or more dominant

hospital providers. However, five of these regions showed no hospital provider dominance primarily due to low population densities attributed to the rurality of the area.

Population estimates and projections were gathered for each of the regions. Sources included the Arizona Department of Economic Security, Claritas Inc., and Indian Health Service. These data were profiled in each of the 31 regions, and shared with the managers of small towns or cities with a population base of at least 4,000 people that included a hospital in the community.

The city managers (or their designee) validated the current population and provided edits to future population projections. These population projections more accurately forecast growth in the markets and serve as the basis of demographic projections for the study. Additionally, two survey questions were asked relative to the role of hospital development in their communities (Appendix F). They are: 1) which phrase best describes how the city perceives its role in hospital development? 2) which of the following best describes the city's/community's needs in hospital development?

Categorize Hospitals and Trend Performance and Utilization

Based on the acute care utilization of the facilities and populations served, 34 hospitals were categorized into four groups for comparison and analysis (see Appendix B).

1. Indian Health Service (IHS) hospitals comprised the first group identified as (IHS Hospitals = 8) This group contains one Tribally-owned and Tribally-managed hospital not affiliated with IHS.
2. Hospitals with an average acute care patient census of 25 or less comprised the second group (Small/Critical Access Hospitals = 12).
3. Rural hospitals with an average acute-care patient census 25 to 50 (Rural Hospitals = 6).
4. Hospitals with an average acute-care patient census greater than 50 (Regional Hospitals = 8).

Regional profiles were developed to include population projections, acute hospital utilization and market share, and acute hospital use rates. The inclusion of IHS discharge data in developing utilization projections likely represents the first time in Arizona history where true medical/surgical use rates could be developed to identify market needs. This factor has increased the reliability and accuracy of the study and enhances the validity of market-based demand for acute hospital beds in regions that border reservations or include reservations within their geographic definitions.

All hospitals receiving Medicare payments submit a full Medicare cost report annually to the Centers for Medicare and Medicaid Services (CMS) with the exception of the Indian Health Service which submits Method E cost reports to CMS on behalf of IHS hospitals. An analysis was conducted for each non-IHS hospital on 13 financial performance ratios among the following five indicators:

- Profitability Indicators
- Liquidity Indicators
- Capital Structure Indicators
- Facility Indicators
- Utilization Indicators

The ratios were trended by facility and compared to national benchmarks as well as study group averages. (Appendix C provides the financial ratio and comparison benchmarks for US Rural Hospitals and US Critical Access Hospitals from 2003-2005.)

Conduct Hospital Management Surveys

In preparation for the distribution of hospital management surveys, Health Solutions and Market Intelligence completed the following tasks:

- Prepared regional profiles that included a brief summary of each region.
- Introduced the regional profiles and individual city manager responses within the region.
- Aggregated city manager response totals for Arizona.
- Provided population estimates by region.
- Identified hospital-specific discharge utilization by region.
- Identified medical/surgical hospital use rates by region.
- Identified hospital bed needs and physician needs based on incremental growth by region.
- Developed three-year trends on hospital specific financial performance indicators from Medicare Cost Report source data.

Subsequently, a survey was developed and submitted to the Rural Health Office which, in turn, sought approval from The University of Arizona's Institutional Review Board (IRB), with subsequent input from the project Advisory Committee, and distribution to hospital managers.

A letter from the study principal at the Rural Health Office (Appendix D) introduced the regional profiles and sought hospital administrator participation in the study through the completion of a 26-question survey (Appendix E).

An abbreviated survey removing non-applicable questions was sent to IHS and tribally-owned and managed facilities. The letters asked for the administrators to review and validate the information and utilization projections. Of vital importance to secure participation in the survey, hospital administrators were informed that none of their responses would be identifiable and all reporting and analysis would be in aggregate form only.

Health Solutions and Market Intelligence contacted each hospital and scheduled on-site survey interviews per administrator availability. The information in the regional profiles was validated by the hospital administrators and the survey was completed. All targeted hospital administrators (100 percent) participated in the survey. They represented eight IHS hospitals, 12 Small/Critical Access Hospitals, six Rural Hospitals, and eight Regional Hospitals.Survey responses were tallied and the following analysis and conclusions were compiled by HSMI.

Analysis Findings

Health Solutions and Market Intelligence (HSMI) provided aggregate regional profiles for statewide market growth and demand projections. Additionally, financial performance profiles by facility were evaluated by peer group to identify trends and challenges facing rural hospitals in Arizona.

The survey responses were categorized by the five areas related to strategic planning/ facility development, financial/capital position, human resource/manpower challenges, community leadership/support, and technology adoption.

Market Growth and Demand

The following projections were submitted by HSMI based on the analysis and findings of the survey.

- Over the five-year period from 2008 to 2013 there will be an increased acute care hospital bed demand of 289 medical/surgical beds to serve new populations in rural Arizona.

- The need for additional acute care hospital beds will be complemented by a need for 227 physicians (Appendix G).

The above Projections are based on the fact that Less than 30 percent of the hospital bed demand can be absorbed by excess hospital bed capacity, and less than 10 percent of the physician demand can be absorbed by rural physician availability. Alternatively, these demands will increase by the closure of hospitals and/or relocation of physicians out of Arizona's rural communities.

Consequently, it is estimated that approximately 200 net hospital beds and 250 net physicians are needed in rural Arizona to satisfy new demand over the next five years. Over 50 percent of this growth will be in communities served by Regional Hospitals.

While current shortages in physician supply will be compounded with additional demand, a hospital's ability to recruit physicians to these rural communities will dictate their ability to place patients. Even if a hospital has capacity, the lack of physicians will dictate utilization.

Financial Performance Profiles

Among the non-IHS peer groups, Small/ Critical Access Hospitals provided the greatest financial variability among group hospitals while the larger Regional Hospitals provided the greatest consistency in financial performance among group hospitals (Appendices H-N). This business characteristic is typical for explaining volatility of small operations and the benefits realized from economies of scale.

The Total Margin Ratio *(Net Income/(Net Patient Service Revenue + Total Other Income))* was utilized as the best Profitability Indicator. The graphs in Appendix H show that 50 percent of the Small/ Critical Access Hospitals and 50 percent of the Rural Hospitals have dipped into negative margins over the last four years threatening their survival while the Regional Hospitals have averaged slightly higher than comparative national norms.

Two Liquidity Indicators were calculated (Appendices I and J). The Current Ratio *(Current Assets/Current Liabilities)* graphs show that approximately 17 percent of the Small/Critical Access Hospitals have liabilities greater than assets which are comparable to 20 percent for the Rural Hospitals and 13 percent for the Regional Hospitals.

The Net Days Revenue in Accounts Receivable *(Accounts Receivable/Uncollectibles)/(Net Patient Service Revenue/Days in Period)* graphs show trends for all three groups comparable

to national benchmarks. However, during interviews with the Hospital Administrators, many identified that there has been an unfavorable change upward in this trend over the last 12 months due to payment delays from payors, notably, Arizona's Medicaid program (AHCCCS). The Capital Structure Indicator calculated was Long-term Debt to Capitalization *(Short-term Notes + Long-term Liabilities)/(Short-term Notes + Long-term Liabilities + Fund Balance)* which is a measure of the importance of debt to a hospital just as a homeowner might measure what percent of their home is mortgaged.

Obviously, the new construction of a hospital will likely have a higher percentage of debt while no debt is a likely example of a leased facility. Based on the graphs in Appendix K, one Small/ Critical Access Hospital and one Regional Hospital have recently recovered from being "upside down" whereby they owe more than the facilities are worth (liabilities are greater than assets) . More importantly is the aggregation of Small/Critical Access Hospitals having little dependence on (or access to) debt due to low reserves.

For a Facility Indicator, the Replacement Viability Ratio *(Investments/Accumulated Depreciation)* was calculated to measure whether or not the hospitals had funded their investments at the same rate of the facilities depreciation thereby being able to pay for the hospitals replacement when necessary. The graphs (Appendix L) show that Regional Hospitals have the highest ratios indicating strong investment reserves relative to the depreciable "age" of the facility. However, 75 percent of the Small/Critical Access Hospitals have no investment reserves or have ratios well below national benchmarks.

Another Facility Indicator calculated to support the Replacement Viability Ratio assessment was Average Age of Plant *(Accumulated Depreciation/Depreciation and Amortization)*. Appendix M shows that all of Arizona's Rural Hospitals and Regional Hospitals have relatively up-to-date facilities with average age of plant ratios below national benchmarks. However, 25 percent of Small/Critical Access Hospitals have ratios above the national averages indicating that the facilities may almost be fully depreciated.

The most consistent comparable measure for a Utilization Indicator is Full Time Equivalent Employees (FTEs) per Adjusted Occupied Bed *((FTEs/((Acute Inpatient Days) X (Total Patient Revenues/Acute Inpatient Revenues)/Days in Period))*. The graphs in Appendix N show the economy of scale benefits realized by Arizona's Rural Hospitals and Regional Hospitals while the Small/Critical Access Hospitals must provide minimum staffing levels regardless of patient volumes. However, all three groups of hospitals maintain average ratios above national benchmarks potentially indicating higher than average nurse to patient ratios and an overall better level of care.

Hospital Administrator Survey Responses

Survey responses were aggregated by the peer groupings to assure hospital confidentiality and facilitate optimum participation.
There were a number of survey response "absolutes". All administrators indicated that the Medicare Cost Report financial data provided in the ratio analysis was accurate for their hospital. None of the hospitals plan to reduce services. While all of the hospitals identified physician recruitment as a development issue, none of them indicated that this would prevent hospital development. All but two hospitals identified the need to recruit nurses and other allied health staff as development issues. While competition is a significant issue in metropolitan areas, none of the Rural Hospitals surveyed identified it as a factor preventing hospital development.

A copy of the survey that was distributed to each hospital administrator is provided in Appendix E. Appendix O provides graphical representations of the survey responses for the following analysis.

Strategic Planning/Facility Development

There is a distinct correlation between the size of a hospital and the frequency and complexity of strategic planning. Over 60 percent of the Regional Hospitals had reviewed their strategic plans within the last six months, compared to none of the IHS Hospitals. All of the Rural Hospitals had reviewed their strategic plans within the last year compared to only 33 percent of the Small/Critical Access Hospitals.

The utilization of outside resources to assist in facility planning and development also varies by facility size. For example, the Regional Hospitals and Rural Hospitals reported that they utilize planning consultants and architects as primary resources 80 percent of the time. On the other hand Small/Critical Access Hospitals indicated that only 10 percent of the time they use such external personnel. IHS Hospitals indicated that they, too, use planning consultants and architects as primary resources only 10 percent of the time.

One hundred percent of the Small/Critical Access Hospitals utilize the services of the Rural Health Office as a "primary" or "occasional" resource, compared to over 20 percent of the IHS Hospitals, and "rarely or never" by the larger hospitals seeking planning and development assistance.

Over 50 percent of the hospitals' strategic plans call for the replacement or development of their facility within the next five years. Rural Hospitals represent the greatest development

with 83 percent indicating plans for development in five years while only 38 percent of the Regional Hospitals have development plans. When these Regional Hospitals were asked what precluded the planning or development of their facilities, all of them identified a "recent facility expansion". Conversely, 83 percent of the Small/Critical Access Hospitals that answered this same question noted the lack of performance, capital, or market growth as the primary deterrent to development.

Despite these deterrents to growth for the Small/Critical Access Hospitals and IHS Hospitals, 60 percent of the hospitals noted renovation and replacement as the primary driver for development while 100 percent of the Rural Hospitals and Regional Hospitals identified strategic and market growth as primary drivers of development.

To meet the challenges of facility development, 50 percent of the hospitals surveyed identified their highest priority in hospital development as the need to improve operating performance. This was followed by another 24 percent identifying the recruitment of staff as the top priority.

Community Leadership/Support

While none of the Rural Hospitals or Regional Hospitals identified City or Tribal government support as a development issue, over 60 percent of the IHS Hospitals and Small/Critical Access Hospitals identified community support as a development concern. Over 20 percent of IHS Hospitals noted that their affiliated tribal government plays a primary role in hospital planning and development, while the other three groups identified that the local city is "rarely or never" involved in the planning process.

When the hospitals were asked to identify the one most important thing that the Arizona Legislature can do to facilitate hospital development, the overwhelming response (50 percent) was for the continued support and an increase in funding allocated through AHCCCS for services to Medicaid recipients. These funds are made possible through two funding pools established by the Arizona State Legislature.

The first funding pool is the Critical Access Hospital (CAH) pool established by the Arizona Legislature in 2002. The CAH pool approriates $1.7 million per year with two-thirds from federal and one-third from state funds. These funds have not increased since the program's inception when it was divided among five CAHs, but is now distributed to 11 hospitals as more of them have received critical access designation.

The second funding pool was established in 2005 by the "Stable, Accessible, Viable and Efficient (SAVE) Rural Hospital Payments law that resulted from research that showed that inadequate Medicaid payments could threaten a hospital's existence.[1] The SAVE pool appropriates $12,158,100 per year, with two-thrids from federal and one-third from state funding. SAVE payments are distributed to 19 hospitals. (IHS hospitals and tribally-owned hospitals operate under section 638 of the Indian Self-Determination Act. do NOT receive appropriations from either the Arizona AHCCCS CAH or SAVE funding pools.)

The next most important issue identified by hospital administrators was the need for support of Hospital Workforce (physician and nurse) education and development. These two issues were also the top two responses to the question on how the Arizona Legislature could help facilitate improved healthcare.

Because IHS Hospitals are funded through Congressional appropriations, there were a handful of responses that noted the Arizona Legislature could facilitate hospital development by urging Congressional increases for IHS appropriations. This limitation resulted in an abbreviated IHS hospital survey being as many of the orignal survey questions were not applicable to IHS facilities. Consequently, responses in the following section are not provided for IHS hospitals.

The city manager interviews (Appendix F) identified that some communities without a hospital are allocating resources to support hospital feasibility analysis and development. In fact, over 50 percent of these non-hospital communities believe there is a need for grant funding or budgeting for the evaluation of health service development.

Financial/Capital Position

Financing/bonding and earnings from operations have historically been the primary sources of capital for many hospitals. The survey responses in this section identified that it continues to be the key source of funding for most of the non-IHS Hospitals. Because of this, there is much less dependence placed on taxing districts, philanthropy, corporate allocation, or third party leasing agreements.

In comparison to Regional Hospitals and Rural Hospitals, Small/Critical Access Hospitals are much more familiar with the availability of grant resources from HRSA, USDA, and the Arizona Chamber of Commerce.

[1] An AHCCCS-sponsored study of all Arizona hospitals found that hospitals are paid 88 cents on the dollar for services to Medicaid patients (Millman Inc., 2008).

The Rural Hospitals and Regional Hospitals were more familiar with venture capital resources to help finance and develop hospitals.

Although 100 percent of the Regional Hospitals were familiar with the financing service available through the Arizona Health Facilities Authority, only about 60 percent of the Rural Hospitals and Small/Critical Access Hospitals were familiar with the AHFA opportunities.

The gaps in leadership familiarity of financial resources available to Rural Hospitals present an opportunity to increase education and awareness by various state agencies, including the Rural Health Office.

Third party payor mix for hospitals has been identified as a challenge affecting profitability. Leading the rankings, the IHS Hospitals averaged a 50 percent favorable rating across all payor groups. While each of the other hospital groups varied in their rankings by payor, there was a consistent theme of unfavorable ratings for Arizona's Medicaid program, AHCCCS. Over 40 percent of the Small/Critical Access Hospitals ranked AHCCCS reimbursements as unfavorable compared to 50 percent of the Rural Hospitals and 80 percent of the Regional Hospitals. AHCCCS can represent 20 percent of a hospital's patient base in some rural areas. The unfavorable rating by Arizona's Rural Hospitals may be representative of hospital C.E.O. apprehension over the financial future of the SAVE and CAH pools that were adopted and funded by the Arizona State Legislature, as explained previously. This, coupled with operating volatility for smaller Rural Hospitals, may present future solvency challenges that may threaten some hospitals' survival.

The Arizona IHS has a proposed budget of $1.3 billion for healthcare facility development for the entire United States over the next 5 years (Appendix P). If Congress funds the budget as proposed, several new Arizona IHS Hospitals and health centers would be constructed using federal funds.This budget is contingent on Congressional appropriations which have been insufficient to meet the IHS facility development needs. Insufficient IHS appropriations is a bellwether for the IHS facility development and is likely the reason many of the IHS Hospital survey responses noted the importance of state legislature support for Congressional allocation of IHS funds to improve healthcare and facility development.

Capital estimates for Small/Critical Access Hospitals over the next five years ranged from $114 million to over $246 million, of which $74 - $147 million would likely comprise hospital facility development and the remaining would be for outpatient facilities and equipment. Rural Hospitals estimate capital expenditures over the next five years at $125

- $252 million where $81 - $155 million is projected for hospital facility development. Regional Hospitals estimate capital expenditures over the next five years at $172 - $347 million where $110 - $210 million is projected for hospital facility development. In total, Arizona's Rural Hospitals are estimating a $2.1 billion dollar capital development budget over the next five years.

Human Resource/Rural Workforce Challenges [2]

Over a five year period, IHS Hospital management (Chief Executive Officer, Chief Nursing Officer, Chief Financial Officer) turnover average was 150 percent. Small/ Critical Access Hospitals turnover average was 80 percent; Rural Hospital turnover average was 77 percent; and Regional Hospitals averaged was 111 percent turnover. While no correlations were identified, the difference between the highest rate and lowest rate is almost double indicating unique challenges and expertise needed at the various hospital groups. CEO and CFO expertise at hospitals designated as Critical Access have specialized skills not necessary at Rural or Regional Hospitals and this may support a lower rate of turnover.

Hospital administrators were asked about causes for physician staff turnover in their communities. The highest response provided by 44 percent of the hospitals identified that the physicians were either retiring or being recruited with more lucrative offers elsewhere.

Rural Hospitals and Regional Hospitals noted that success in recruitment and retention reduced turnover and related challenges. However, unique to 25 percent of the Small/ Critical Access Hospitals was the challenge of a revolving door for J-1 Visa physicians. Furthermore, another 16 percent identified that physicians do not want to "take call".

Hospitals that employ physicians on their staff (including hospitalists), also half of the IHS Hospitals and 33 percent of the Small/Critical Access Hospitals, indicated that they do not have recruitment challenges.

Additionally, while all of the hospital administrators identified physician recruitment as a development issue, none of them indicated that this would prevent hospital development. All but two hospitals identified the need to recruit nurses and other allied health staff as development issues.

[2] In January, 2008 Arizona Governor Napolitano publicly recognized the existence of a state-wide health care workforce supply and demand challenge. She signed an Executive Order requiring the Arizona Department of Commerce to coordinate a public-private effort to develop a health care workforce plan designed to meet the needs of 21st Century Arizona, and provide a framework and timeframe to develop a comprehensive workforce plan.

Technology Adoption

To better understand technology in Arizona's Rural Hospitals, each administrator was asked which phase of technology adoption best describes the role technology plays in the hospital. The phrase, "it is an infrastructure issue" was selected by 42 percent of the Small/Critical Access Hospitals followed with another 42 percent for "it is a strategic initiative". The remaining 18 percent for this group identified that "it is a Return On Investment (ROI) decision". Half of the IHS Hospitals identified that "it is dictated by corporate" referring to the IHS system infrastructure provided. However, across all hospitals, 42 percent noted that technology "is a strategic initiative".

All of the Rural Hospitals reported that they are using telemedicine applications for clinical consultation at a distant site compared to approximately 75 percent for Small/ Critical Access Hospitals, IHS Hospitals, and Regional Hospitals.

Sixty-nine percent of the hospitals reported having completed a workflow analysis and business plan for the implementation of an Electronic Health Record System (EHRS). Additionally, 82 percent had already implemented an EHRS internally. Of the hospitals that have not implemented an EHRS, most of them are at some stage of the process with expected completion within the next two years.

Technology adoption for rural Arizona hospitals is a strategic necessity that directly affects hospital infrastructure and development. Technology planning and implementation will increasingly affect facility design and development as Arizona's hospitals complete the transition to EHRS. Equipment and technology make up a larger proportion of smaller facilities budgeted capital costs than larger hospitals and present development challenges often overshadowing Return On Investment (ROI) analysis.

Summary and Conclusions

Rural Arizona has four distinct groups of hospital facilities, each with their own unique challenges as described below.

1. **Indian Health Service/Tribal Hospitals**. These hospitals face challenges familiar to the Small/Critical Access Hospitals, in that they face workforce recruitment challenges, inadequate reimbursement issues, and operational volatility challenges. They are dependent largely on Congressional appropriations to meet facility development needs. Fluctuating levels of annual appropriations have caused delays in facility planning and development,

and have impacted the hospitals' capacity to implement effective strategic planning.

A national directive to IHS now requires eligible tribal members seeking health care through IHS Hospitals and clinics to join Medicare and/or Medicaid, with IHS being the payor of last resort. While the hospitals have risen to this challenge as best they can, they have found it difficult to enroll residents who travel vast distances to seek care, and do not bring needed paperwork to prove residency. Further, tribal elders often do not have birth certificates required for enrollment as their birth dates pre-date modern record-keeping methods within tribal cultures.

Another challenge faced by IHS hospitals is the need for training new personnel in coding and billing methodology required by CMS for reimbursement. These hospitals have been faced with a "new way of doing business" that has required an entire paradigm shift for their personnel, in order that they can operate like a business, similar to the non-IHS hospitals. Finally, most IHS/Tribal Crtical Access Hospitals have not taken advantage of swing bed opportunities that can benefit their elderly patients.

2. **Small/Critical Access Hospitals** look to the pressing demands of their physician recruitment as an important development effort that impacts their survival strategy. Over the past eight years, 16 of Arizona's Small Hospitals converted to Critical Access designation in order to benefit financially through better Medicare reimbursement available through the designation. (Of the 16, one IHS Hospital reverted to its former PPS system, and another IHS Hospital closed but retained its outpatient clinic service.) In addition, these hospitals face the following challenges.

   a. Debt may be one of the biggest challenges for Small Rural Hospitals. Community growth has forced facility expansion for many Small Rural Hospitals, but reimbursement methodologies may not be as beneficial to them as the reimbursement methods for Small Rural Hospitals designated as Critical Access. Further, financial performance and market potential is often marginal at best. As a result replacement is difficult to justify with most lending entities.

   b. The Small/Critical Access Hospitals and IHS Hospitals are both plagued by the challenges of inefficiency and exponential affect of operational volatility. The loss of just one physician in their community could determine the financial survival of the hospital. This has forced the

adoption of an employed medical staff model at many of the hospitals to offset risks. Increasingly, these hospitals are hiring hospitalists that provide dependable care and efficient patient management without the pressure of accountability to another entity.

c. Technology adoption is also a burden in many Critical Access Hospitals as the system start-up and maintenance costs to match those of larger hospitals put a disproportionate burden on the overhead of these small hospitals.

d. Federal and state grant funding to support electronic health record implementation is very limited.

The Rural Health Office plays a vital role in facilitating education and development resources for these facilities, but has experienced budget shortfalls resulting in fewer personnel and fewer services. Population growth in many of these rural communities is static. As a result, the hospitals are forced to adopt a "maintenance" and defensive approach to facility development. Further, it has contributed to situations in which the facilities are outdated and obsolete, and have been fully depreciated for years.

3. **Rural Hospitals** represent the "purgatory" of rural healthcare. As their size dictates, they lack the operating efficiencies and access to capital enjoyed by the Regional Hospitals.

4. The larger **Regional Hospitals** in general, have recently completed renovations and expansions, and have the capital reserves and economies of scale to weather future financial challenges. Because of their positive financial position, there are many capital and financing options available to them. They, share similar challenges to those faced by all Rural Arizona Hospitals in physician and staff recruitment and AHCCCS reimbursement shortfalls, however, population growth in their communities tends to be faster than that of the "rural rural" (or frontier) hospital communities. Additionally, over 50 percent of Arizona's population growth will be serviced by these Regional Hospitals.

Recommendations

The survival of Arizona's Small Rural Hospitals is fundamental to the health and economic well-being of the people and the communities they serve. Some of the State's

small hospital facilities are in extreme states of disrepair. In these cases, it is more cost effective to build new facilities than attempt to repair worn out buildings in order to meet state physical facility regulations.

It is important to emphasize that constructing new health care facilities is not a panacea for resolving rural health care issues, although new hospital environments are, no doubt, strong morale boosters to rural residents who are dependent on the hospitals for health care.

Rural Hospital issues are many. They are complicated and intertwined. Facility expansion or construction must be accompanied by solutions that address other problems identified in this report such as workforce recruitment and retention, the availability of technology to deliver better care and to maintain accurate patient medical records.

The Advisory Committee acknowledges the current national and state economic crises that confer limitations in resource distribution. Nevertheless, a compelling case is made to public policy-makers and private sector entrepreneurs on the extent to which the State's Small Rural Hospitals need explicit financial and policy support that will enable them to not only survive, but also to more effectively deliver health care and be a major economic driver in their communities. To this end, the following recommendations are presented. [3]

1. The Arizona Health Facilities Authority should support replacement facilities or renovation projects for the state's Small/Critical Access Hospitals, including those operated by IHS and tribal-affiliated organizations. Such support should consider the important role these hospitals play in delivering care to rural people, as well as the importance of the economic impact they have in their communities. Financial viability and market growth should not be the major drivers behind support for facility replacement or renovation projects.

2. Community leaders should urge and support *à la carte* financing opportunities for Small/Critical Access Hospitals, including those operated by the Indian Health Service (IHS) and tribal-affiliated organizations, to renovate, rebuild or replace their facilities in order to meet the growing population demand for services.

3. The Arizona State Legislature should authorize a technical assistance program for Critical Access Hospitals that need new facilities, to assist them with feasibility studies, planning and architectural assistance.

[3] Advisory Committee members employed by Federal and Arizona state agencies declined from comment on recommendations made in this reoport due to the nature of their positions.

4. The Arizona State Legislature should examine new methods for providing incentives to physicians and nurses willing to practice in Arizona's high shortage rural and frontier areas, including Native American communities.

5. The Arizona State Legislature should **increase** the funding pool for Critical Access Hospitals, proportionate with the increasing number of Rural Hospitals that receive Critical Access designation.

6. The Arizona State Legislature should continue to appropriate funds for the Stable, Accessible, Viable and Efficient (SAVE) pool discussed in this report in order that the eligible Critical Access and Rural Hospitals can remain viable and build new facilities, as needed.

7. Arizona's Congressional delegation should provide leadership in urging Congress to increase Congressional appropriations for the Indian Health Service facility capital budget, and members of the Arizona State Legislature should voice support for such an increase to the Congressional delegation.

8. Programs should be generated by public and private sector agencies that provide mechanisms to recruit and retain health care providers and hospital executives willing to work in rural Arizona.

9. The Arizona State Legislature should increase the funding appropriation designated for the Rural Health Office at The University of Arizona Mel an Enid Zuckerman College of Public Health, with an explicit mandate that this office direct these resources to improve access to care and increase the viability of the most vulnerable rural hospitals.

10. National and state health care reimbursement mechanisms should provide incentives for Rural Hospitals to implement health information technology applications, and to access telemedicine technology and e-prescribing technology.

11. Municipalities, tribal governments, and local Chambers of Commerce should recognize, acknowledge, and support the small hospitals serving their communities, and the importance of the economic impact these hospitals have on the local economy by budgeting funds to support the planning and development of hospitals and medical services in their communities.

12. Recognizing that strategic planning is integral to Rural Hospital survival, hospital administrators should conduct short- and long-term strategic plans, and routinely monitor their progress of such plans, and use the plans as pathways to the future.

13. The Indian Health Service should adopt a policy that urges Rural Hospitals under its jurisdiction to regularly review and update their strategic plans, and to use the plans as pathways to the future.

14. The Indian Health Service should establish a formal procedure for eligible IHS Critical Access Hospitals to apply to CMS for swing bed services in order that they can better meet the needs of their elderly patients.

15. A state-wide study is needed of the economic impact of Arizona's rural health care systems on the health of county and state economies.

16. An ongoing communications and information dissemination system is needed to inform members of the Arizona State Legislature and Arizona's Congressional delegation about the status of the health care systems serving their communities.

17. Arizona's Rural Hospitals and Critical Access Hospitals should collaborate in the design and implementation of activities that focus on hospital finance and workforce development.

The Arizona Rural Hospital Facilities and Market Study 2008
Appendices

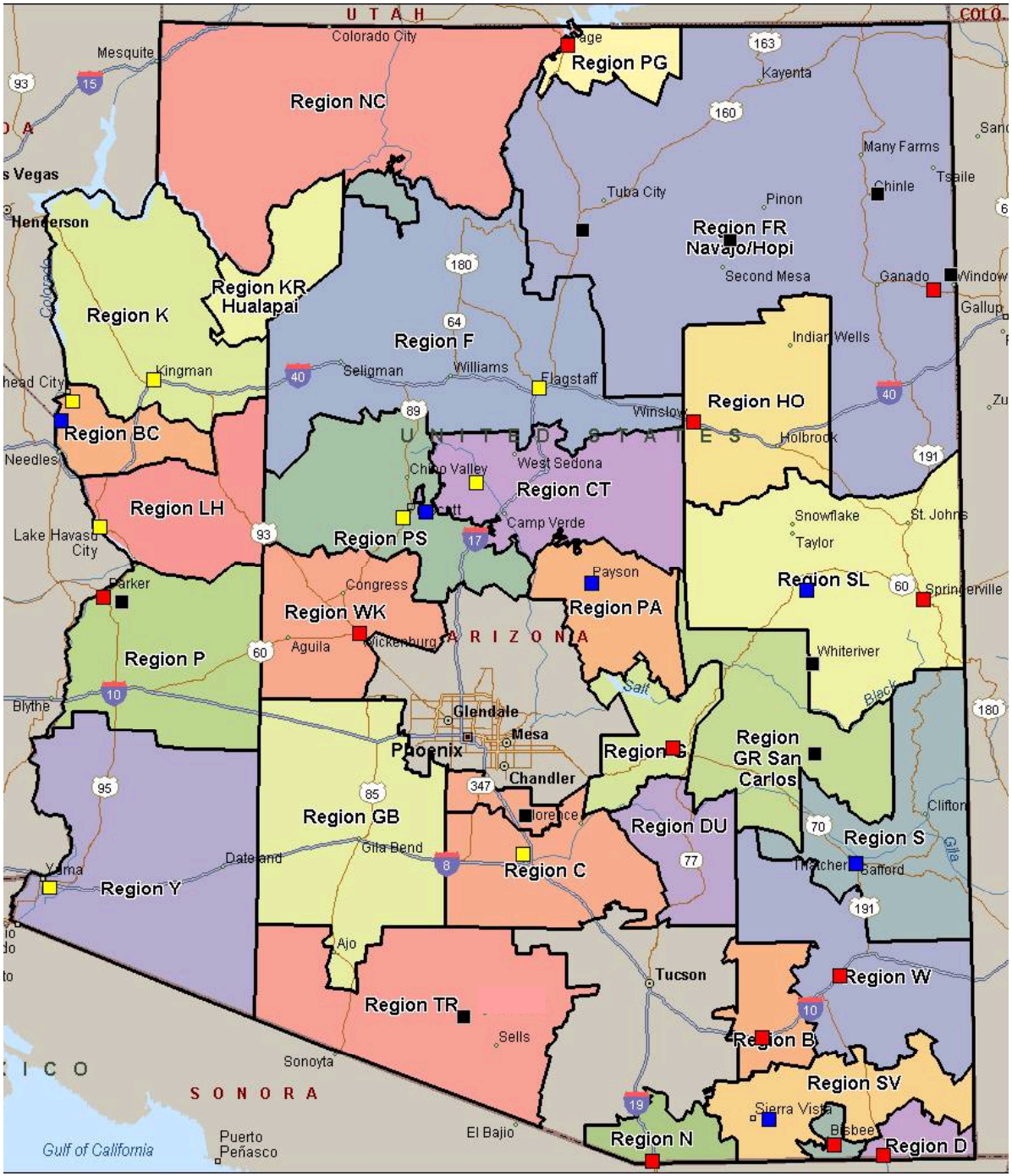
Appendix A

31 Regions
34 Hospitals

Indian Hospitals (8)	■
Small/CAH (12)	■
Rural Hospitals (6)	■
Regional Hospitals (8)	■

Coding initials were selected as a method for identifying regions

(See Appendix B for hospital listing)



Appendix A

31 Region Listing by Zip Code

Region B
85602 Benson
85609 Dragoon
85630 Saint David

Region BC
86426 Fort Mohave
86427 Fort Mohave
86429 Bullhead City
86430 Bullhead City
86433 Oatman
86436 Topock
86438 Yucca
86439 Bullhead City
86440 Mohave Valley
86442 Bullhead City
86446 Mohave Valley

Region BS
85603 Bisbee
85620 Naco

Region C
85221 Bapchule
85222 Casa Grande
85223 Arizona City
85228 Coolidge
85230 Casa Grande
85231 Eloy
85232 Florence
85239 Maricopa
85241 Picacho
85272 Stanfield
85291 Valley Farms

Region CR Gila River
85247 Sacaton

Region CT
85931 Forest Lakes
86017 Munds Park
86024 Happy Jack
86322 Camp Verde
86324 Clarkdale
86325 Cornville
86326 Cottonwood
86331 Jerome
86335 Rimrock
86336 Sedona
86339 Sedona
86340 Sedona
86341 Sedona
86342 Lake Montezuma
86351 Sedona

Region D
85607 Douglas
85608 Douglas
85626 Pirtleville
85655 Douglas

Region DU
85237 Kearny
85292 Winkelman
85618 Mammoth
85623 Oracle
85631 San Manuel

Region FR Havasupai
86435 Supai

FR Navajo/Hopi
86020 Cameron
86030 Hotevilla
86033 Kayenta
86034 Keams Canyon
86035 Leupp
86039 Kykotsmovi Vill.
86042 Polacca
86043 Second Mesa
86044 Tonalea
86045 Tuba City
86053 Kaibeto
86054 Shonto
86502 Chambers
86503 Chinle
86504 Fort Defiance
86505 Ganado
86506 Houck
86507 Lukachukai
86508 Lupton
86510 Pinon
86511 Saint Michaels
86512 Sanders
86514 Teec Nos Pos
86515 Window Rock
86520 Blue Gap
86535 Dennehosto
86538 Many Farms
86540 Nazlini
86544 Red Valley
86545 Rock Point
86547 Round Rock
86556 Tsaile

Region F
86001 Flagstaff
86002 Flagstaff
86003 Flagstaff
86004 Flagstaff
86011 Flagstaff
86015 Bellemont
86016 Gray Mountain
86018 Parks
86023 Grand Canyon
86038 Mormon Lake
86046 Williams
86320 Ash Fork
86337 Seligman

Region G
85273 Superior
85501 Globe
85502 Globe
85532 Claypool
85539 Miami

Region GB
85321 Ajo
85322 Arlington
85326 Buckeye
85337 Gila Bend
85343 Palo Verde
85354 Tonopah

Region GR
85530 Bylas
85542 Peridot
85550 San Carlos

Region HO
85942 Woodruff
86025 Holbrook
86028 Petrified Forest
86029 Sun Valley
86031 Indian Wells
86032 Joseph City
86047 Winslow

Region K
86401 Kingman
86402 Kingman
86409 Kingman
86411 Hackberry
86412 Hualapai
86413 Golden Valley
86431 Chloride
86437 Valentine
86441 Dolan Springs
86444 Meadview
86445 Willow Beach

Region KR Hualapai
86434 Peach Springs

Region LH
85360 Wikieup
86403 Lake Havasu City
86404 Lake Havasu City
86405 Lake Havasu City
86406 Lake Havasu City

Region N
85621 Nogales
85624 Patagonia
85628 Nogales
85640 Tumacacori
85646 Tubac
85648 Rio Rico

Region NC
86021 Colorado City
86022 Fredonia
86036 Marble Canyon
86052 North Rim
86432 Littlefield

Region NCR
86040 Page

Region P
85325 Bouse
85328 Cibola
85334 Ehrenberg
85344 Parker
85346 Quartzsite
85348 Salome
85357 Wenden
85359 Quartzsite
85371 Poston

Region PA
85541 Payson
85544 Pine
85547 Payson
85553 Tonto Basin
85554 Young

Region PS
85362 Yarnell
86301 Prescott
86302 Prescott
86303 Prescott
86304 Prescott
86305 Prescott
86312 Prescott Vly
86313 Prescott
86314 Prescott Vly
86321 Bagdad
86323 Chino Valley
86327 Dewey
86329 Humboldt
86332 Kirkland
86333 Mayer
86334 Paulden
86338 Skull Valley
86343 Crown King

Region S
85531 Central
85533 Clifton
85534 Duncan
85535 Eden
85536 Fort Thomas
85540 Morenci
85543 Pima
85546 Safford
85548 Safford
85551 Solomon
85552 Thatcher
85922 Blue

Region SL
85901 Show Low
85902 Show Low
85911 Cibecue
85912 White Mntn Lk
85923 Clay Springs
85924 Concho
85926 Fort Apache
85928 Heber
85929 Lakeside
85930 McNary
85933 Overgaard
85934 Pinedale
85935 Pinetop
85936 Saint Johns
85937 Snowflake
85939 Taylor
85941 Whiteriver
85920 Alpine
85925 Eagar
85927 Greer
85932 Nutrioso
85938 Springerville
85940 Vernon

Region SV
85611 Elgin
85613 Fort Huachuca
85615 Hereford
85616 Huachuca City
85617 Mc Neal
85635 Sierra Vista
85636 Sierra Vista
85638 Tombstone
85650 Sierra Vista
85670 Fort Huachuca

Region TR
85634 Sells

Region W
85605 Bowie
85606 Cochise
85625 Pearce
85632 San Simon
85643 Willcox
85644 Willcox

Region WK
85320 Aguila
85332 Congress
85358 Wickenburg
85390 Wickenburg

Region Y
85333 Dateland
85336 Gadsden
85347 Roll
85349 San Luis
85350 Somerton
85352 Tacna
85356 Wellton
85364 Yuma
85365 Yuma
85366 Yuma
85367 Yuma
85369 Yuma

Appendix A

Phoenix & Tucson Zips not included in study

85001 Phoenix
85002 Phoenix
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85087 New River
85099 Phoenix
85201 Mesa
85202 Mesa
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85207 Mesa
85208 Mesa
85209 Mesa
85210 Mesa
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85212 Mesa
85213 Mesa
85214 Mesa
85215 Mesa
85216 Mesa
85217 Apache Junction
85218 Apache Junction
85219 Apache Junction
85220 Apache Junction
85224 Chandler
85225 Chandler
85226 Chandler
85227 Chandler Heights
85233 Gilbert
85234 Gilbert
85235 Hayden
85236 Higley
85242 Queen Creek
85243 Queen Creek
85244 Chandler
85245 Red Rock
85246 Chandler
85249 Chandler
85250 Scottsdale
85251 Scottsdale
85252 Scottsdale
85253 Paradise Valley
85254 Scottsdale
85255 Scottsdale
85256 Scottsdale
85257 Scottsdale
85258 Scottsdale
85259 Scottsdale
85260 Scottsdale
85261 Scottsdale
85262 Scottsdale
85263 Rio Verde
85264 Fort McDowell
85266 Scottsdale
85267 Scottsdale
85268 Fountain Hills
85269 Fountain Hills
85271 Scottsdale
85274 Mesa
85275 Mesa
85277 Mesa
85278 Apache Junction
85279 Florence
85280 Tempe
85281 Tempe
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85287 Tempe
85289 Tempe
85290 Tortilla Flat
85296 Gilbert
85297 Gilbert
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85309 Luke AFB
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85313 Glendale
85318 Glendale
85323 Avondale
85324 Black Canyon City
85329 Cashion
85331 Cave Creek
85335 El Mirage
85338 Goodyear
85339 Laveen
85340 Litchfield Park
85341 Lukeville
85342 Morristown
85345 Peoria
85351 Sun City
85353 Tolleson
85355 Waddell
85361 Wittmann
85363 Youngtown
85372 Sun City
85373 Sun City
85374 Surprise
85375 Sun City West
85376 Sun City West
85377 Carefree
85378 Surprise
85379 Surprise
85380 Peoria
85381 Peoria
85382 Peoria
85383 Peoria
85385 Peoria
85387 Surprise
85388 Surprise
85396 Buckeye
85601 Arivaca
85614 Green Valley
85619 Mount Lemmon
85622 Green Valley
85627 Pomerene
85629 Sahuarita
85633 Sasabe
85637 Sonoita
85639 Topawa
85641 Vail
85645 Amado
85652 Cortaro
85653 Marana
85654 Rillito
85701 Tucson
85702 Tucson
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85777 Tucson
86520 Blue Gap
86545 Rock Point

Appendix B

Small/Critical Access Hospitals:

Wickenburg Regional Hospital
Northern Community Community Hospital
La Paz Regional Hospital
Benson Hospital
Copper Queen Community Hospital
Southeastern Arizona Medical Center
Cobre Valley Community Hospital
Sage Memorial Hospital
Little Colorado Medical Center
Carondolet Holy Cross Hospital
Page Hospital
White Mountain Regional Medical Center

Indian Health Services Hospitals:

Chinle Health Care Facility
Fort Defiance Indian Hospital
Hopi Healthcare Center
Hu Hu Kam Memorial Hospital**
Parker Hospital
San Carlos Hospital
Sells Hospital
Whiteriver Hospital

Rural Hospitals:

Valley View Medical Center
Mt. Graham Community Hospital
Summit Regional Medical Center
Sierra Vista Regional Medical Center
Payson Regional Medical Center
Yavapai Regional Medical Center (P. Valley)

Regional Hospitals:

Verde Valley Medical Center
Kingman Regional Medical Center
Flagstaff Medical Center
Casa Grande Regional Medical Center
Havasu Regional Medical Center
Yuma Regional Medical Center
Western Arizona Regional Medical Center
Yavapai Regional Medical Center (Prescott)

**Non-IHS Hospital

Appendix C

Financial Ratio and Comparison Benchmarks

	US Rural Hospitals (1)			US Critical Access Hospitals (3)		
	2003	2004	2005	2003	2004	2005
Profitability Indicators						
Total Margin	3.41	4.31	5.25	2.29	1.79	2.63
Cash Flow Margin (2)	0.20	1.60	2.10	3.83	4.08	4.73
Return on Equity	7.23	8.33	9.23	4.87	4.83	5.87
Liquidity Indicators						
Current Ratio	1.96	1.96	2.00	2.08	2.08	2.11
Days Cash on Hand	51.7	55.8	71.8	46.62	48.19	53.42
Net Days Revenue in Accounts Receivable	61.2	57.7	55.2	60.74	58.28	57.40
Capital Structure Indicators						
Equity Financing	51.2	52.1	54.6	61.97	62.32	62.23
Debt Service Coverage (2)	3.90	4.57	5.00	2.69	2.61	2.93
Long-term Debt to Capitalization (2)	36.0	34.0	33.4	21.83	21.73	22.47
Facility Indicators						
Replacement Viability (2)	25.90	16.27	23.00	-	-	-
Average Age of Plant	8.7	10.1	10.1	11.43	11.27	10.94
Utilization Indicators						
Average Daily Census Acute Beds	29.5	29.7	27.8	3.10	3.37	3.99
FTE's per Adjusted Occupied Bed	3.75	3.74	3.67	6.22	5.93	5.92

(1) ***Source:*** *2007 Almanac of Hospital Financial & Operating Indicators from Ingenix based on* ***Medicare Cost Report*** *averages*

(2) ***Hospital*** *Comparisons are based on* ***Medicare Cost Reports, audited financials, and indicator data submitted by hospitals***

(3) ***Source:*** *Calculations adopted from the CAH Financial Indicators Report Team based on* ***Medicare Cost Reports*** *averages*

and funded by Office of Rural Health Policy, HRSA, and US department of Health and Human Services.

Appendix D

Community Environment & Policy
Phone (520) 626-3589
FAX (520) 626-8009

Rural Health Office

THE UNIVERSITY OF ARIZONA
Mel and Enid Zuckerman College of Public Health

1295 Martin Avenue
PO Box 245210

Dear _____:

The Rural Health Office at the University of Arizona has subcontracted with Health Solutions and Market Intelligence (HSAMI) to implement a state-wide rural health facilities study. The project is being funded by the Arizona Health Facilities Authority, a public body funded by the state legislature, which provides tax-exempt financing for nonprofit health care institutions and providers in Arizona.

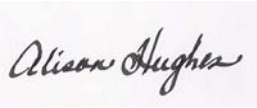
As you know, Arizona and Nevada are the fast growing states in the country. We are extremely aware of the implications that growth has for the future of the health care industry. The study will provide us with an understanding of which pockets of the state are or will be planning for new health care facilities, and will be useful in making recommendations regarding available funding opportunities.

Mike Albertson from HSAMI will be contacting you by telephone in the near future to schedule an appointment to meet with you regarding the future health facility needs for your hospital. I am writing to encourage you to discuss this project with him, and to provide him with information that will contribute to an examination of the rural health needs of our state. Participation in the survey is entirely voluntary, and you may withdraw at any time during the interview. Individual responses will not be made public. Only an aggregate analysis will be provided in the final report, and you will receive a copy of that report.

Attached you will find the survey for your advance review and discussion with Mr. Albertson at your future meeting.

Thank you in advance for your cooperation. If you have any questions, please do not hesitate to call me at 520-626-6253 or email me at ahughes@u.arizona.edu

Sincerely,



Alison M Hughes, MPA
Director, Arizona Rural Hospital Flexibility Program
Rural Health Office
Attachment

Appendix E

Arizona Rural Hospital Facility Assessment Survey

The purpose of this survey is to understand what challenges rural hospitals in the State of Arizona face in relation to facility development and replacement. It is understood that there are a number of factors that influence facility development decisions. For this reason, the survey has been divided into four sections:

- **Market Growth and Facility Needs**
- **Financial/Capital Position**
- **HR & Technology Limitations**

Individual hospital responses to this survey will not be made public. Only aggregate analysis will be provided in the final report. It is understood that your participation in this survey is voluntary, and that you may withdraw at any time.

Market Growth and Facility Needs

The attached profile provides a regional review of your hospital's market share and utilization with market growth projections. Additionally, a summary of interviews with city managers is provided to identify population growth expectations in the region. This survey also includes perspectives on hospital development roles and community needs for hospital development. *Please review the attached profile to address questions in this section.*

1a) When was your hospital's strategic plan last reviewed by the board/corporate?

- ❑ Over two years ago/do not know
- ❑ One - two years ago
- ❑ Within the last year - six months
- ❑ Within last six months

1b) Which phrase best describes your hospital's strategic plan & planning process?

- ❑ The strategic plan is done every 3-5 years and sits on the shelf
- ❑ The strategic plan is essentially the top 3-5 things to be done as determined by the CEO/Board Chair
- ❑ The strategic plan is reviewed annually by a planning team and incorporates goals, objectives, and actions that all have assigned responsibility (a management action plan)
- ❑ The strategic plan incorporates strategic and operational analysis, management action plan, operating budget and multi-year capital plan and is reviewed and approved by the board at least annually
- ❑ The strategic planning process includes a strategic plan with integrated management action plan tied to: A) operating budget; B) capital plan; C) master facility plan; D) management performance evaluation/bonus - and includes board reports on operating objectives (dashboards) and strategic objectives (Management Action Plan) at least quarterly

1c) Does your hospital's strategic plan incorporate the development or replacement of your hospital over the next five years?

- ❑ Yes (please go to Question **1d**)
- ❑ No (please go to Question **1e**)

1d) What was the **primary** driver for the decision to develop/replace your hospital?

(select one)

- ❑ Community/market growth
- ❑ Strategic/new program growth and development
- ❑ The facility needs renovation
- ❑ The facility needs replacement
- ❑ Other (please specify) _____

1e) What **primary condition** exists that precludes the development or replacement of your hospital?

(select one)

- ❑ We recently built/replaced/expanded the hospital
- ❑ We do not have the market share/growth to sustain new facility development.
- ❑ Competitor development
- ❑ We lack the operating performance/capital necessary for development
- ❑ Recruitment of qualified staff is a more pressing need at this time
- ❑ Other (please specify) _____

2a) Are you planning to **expand or add** new hospital services in the next two years (e.g., inpatient services, diagnostic services)?

- ❑ Yes (please describe services)_____
- ❑ No

2b) Are you planning to **reduce** existing hospital services in the next two years (e.g., inpatient, services, diagnostic services)?

- ❑ Yes (please describe services)_____
- ❑ No

3a) Which (***one***) statement in general best represents your payor mix situation/perspective?

- ❑ We consider our payor mix satisfactory/favorable
- ❑ We have implemented deliberate efforts to improve our payor mix
- ❑ We do not have a specific payor mix objective
- ❑ Trends in our payor mix are beyond our control
- ❑ Our payor mix is representative of the community we serve
- ❑ Other (please explain)_____

3b) How do you rate the following payors for hospital services?

1 - Favorable 2 - Fair 3 - Unfavorable 4 - Not Applicable

___ Traditional Medicare
___ Medicare (D/Managed)
___ Commercial/Indemnity
___ HMO/PPO Managed Care
___ Medicaid/AHCCCS
___ Other State
___ Private/Business/Occupational Med. Contracts
___ Indian Health Services
___ Other Federal

4) Which characteristics accurately describe the community's/city's role in participating in hospital development?

(select all that apply)

- ❑ Hospital development is primarily the responsibility of the hospital
- ❑ The city plays a major role in facilitating/supporting hospital development
- ❑ There is a strong commitment of the Taxing District
- ❑ There is a questionable commitment of the Taxing District
- ❑ Our hospital has good philanthropic support from the community
- ❑ Our hospital board is the primary representation of community support
- ❑ Other (please specify) _____

5a) Please rate the following entities as to the frequency of use in assisting in planning and development of your hospital facility.

1 - Primarily/Often 2 - Occasionally 3 - Rarely/Never 4 - NA

___ Our corporate parent/affiliate
___ Our internal development team
___ Strategy/facility planning consultants
___ Architects/contractors
___ City leadership
___ Arizona Office of Rural Health
___ Financing entity
___ Equipment vendor

5b) Please rank from highest to lowest your strategic priorities relative to hospital development?

1 - First priority 7 - Last priority (NA- not a priority)

___ Improve operating performance
___ Identify sources of capital
___ Recruit staff
___ Build community support
___ Attain hospital board approval/buy-in
___ Develop a strategic/capital plan & financial feasibility assessment
___ Identify viable architect/contractor
___ Other (please specify)_____
___ Other (please specify)_____
___ Other (please specify)_____

6a) What do you believe is the ***one*** most important thing that the Arizona Legislature can do to facilitate ***hospital development*** in rural Arizona?

_____

_____

6b) What do you believe is the ***one*** most important thing that the Arizona Legislature can do to facilitate ***improved healthcare*** in rural Arizona?

_____

_____

Finance/Capital Position

The attached profile provides a financial ratio analysis of your hospital's trended position with national comparisons. *Please review the attached profile to address questions in this section.*

7a) Do the Medicare Cost Report Ratios in the attached profile accurately represent your hospital's financial performance?

- ❑ Yes
- ❑ No (please describe why)_____

7b) Rate each of the following statements as to their applicability to your hospital's access to capital:

1- Likely 2- Possible 3- Not Likely 4- Not Applicable

___ We have assets/land/investments that may provide unrealized gains
___ We have capacity in our Taxing District authority to increase revenue
___ We have Donor(s) who have informally pledged financial support
___ Our corporate parent has assured us that capital is available
Other Source not apparent on Cost Report (_____)

8) How much do you plan/estimate on spending over the next five years on hospital facility development?

Hospital Facility	**Other Facility**	**Equipment**
❑ Less than $1m	❑ Less than $1m	❑ Less than $50k
❑ $1m - $5m	❑ $1m - $5m	❑ $50k - $100k
❑ $5m - $10m	❑ $5m - $10m	❑ $100k - $500k
❑ $10m - $20m	❑ $10m - $20m	❑ $500k - $1m
❑ $20m - $30m	❑ $20m - $30m	❑ $1m - $5m
❑ More than $30m	❑ More than $30m	❑ More than $5m

9a) What will be your primary source of capital for the needs above?

_____

9b) What is your familiarity/utilization with the following capital entities/resources?

1 - Familiar (and have used) 3 - Not Familiar (interested in learning more)
2 - Familiar (but have not used) 4 - Not Familiar (not interested) 5 – NA

___ Our regional/local/community/bank
___ Arizona Health Facilities Authority
___ Industrial Development Authority
___ Critical Access Hospital Designation
___ HUD 242 program
___ Rural Hospital/HRSA Grants
___ USDA Grants and Loans (Enterprise Zone)
___ Arizona Department of Commerce Grants/Programs
___ Venture Capital Firms specializing in Rural Hospitals
___ Venture Development Firms specializing in lease/sale

HR & Technology Limitations

10) Does your hospital currently have high speed connectivity for rapid transmission of health care data?

❑ Yes (please describe services: Broadband T-1, T-3, Satellite access, etc.)
_____

❑ No

11a) Does your hospital currently use telemedicine for clinical consultation at a distant site?

- ❑ Yes
- ❑ No (see next question)

11b) If you answered no above and would like to gain access to telemedicine technology, please list specialties in which there is interest (e.g., radiology, pathology, dermatology, psychiatry, ophthalmology, pediatrics, etc.).

_____

_____

12a) Has your hospital completed a work flow analysis and a business plan for implementation of an electronic health record system?

- ❑ Yes (both)
- ❑ Work flow analysis only
- ❑ Business plan only
- ❑ No (neither)

12b) Has your hospital implemented any electronic health record system internally?

- ❑ Yes (please explain) _____
- ❑ No (see next question)

12c) If no to question above, what plans are in place to plan and implement an electronic health record system (e.g., electronic patient record, lab, pharmacy, etc.)? Please describe: _____

13) Which **two** phrases best describe the role technology plays in your hospital facility development?

1 - Dominant Role 2 - Secondary Role (choose only one secondary)

___ Technology is an ***infrastructure issue*** that we build our facility around
___ Technology adoption is a ***ROI decision*** not necessarily a facility development consideration
___ Technology adoption is ***dictated by corporate***
___ We consider technology adoption as an ***alternative to facility development***
___ Technology adoption is considered a ***strategic*** initiative

14) Which best describes your hospital's admitting physician staff turnover?

- ❑ We do not have a turnover issue with our admitting physicians because we employ/contract for staff
- ❑ We do not have a turnover issue with our admitting physicians because we have an effective recruitment and retention program
- ❑ We have Visa (J1/ H1-B) revolving door turnover issue
- ❑ We have a Generation Y (young physician) turnover issue
- ❑ Our admitting Physician turnover issue is primarily due to (please specify)

  _____

15) What has been the hospital's management turnover for the following three positions?

Chief Executive Officer	**Chief Financial Officer**	**Chief Nursing Officer**
❑ One over 5 yr./none	❑ One over 5 yr./none	❑ One over 5 yr./none
❑ Two over 5 years	❑ Two over 5 years	❑ Two over 5 years
❑ Three over 5 years	❑ Three over 5 years	❑ Three over 5 years
❑ Four over 5 years	❑ Four over 5 years	❑ Four over 5 years
❑ Five+ over 5 years	❑ Five+ over 5 years	❑ Five+ over 5 years

16) Rank each issue regarding your hospital facility development efforts?

1 – Dominant Issue (use only once) 2 – Major Issue 3- Concern 4- Non Issue

___ Difficulty in physician recruitment
___ Difficulty in nurse recruitment
___ Difficulty in recruitment of allied health staff (please specify) _____
___ Lack of access to capital/financing
___ Limited expertise in developing an strategic and financial plan
___ Facility development vs. technology development conflicts
___ Lack of expertise to assist in various areas of development process
___ Lack of community/population growth and utilization
___ Lack of support from community/civic leadership
___ Other (please specify) _____
___ Other (please specify) _____
___ Other (please specify) _____

Appendix E – IHS Survey

Arizona Rural Hospital Facility Assessment Survey

The purpose of this survey is to understand what challenges rural hospitals in the State of Arizona face in relation to facility development and replacement. It is understood that there are a number of factors that influence facility development decisions. For this reason, the survey has been divided into four sections:

- **Market Growth and Facility Needs**
- **Financial/Capital Position**
- **HR & Technology Limitations**

Individual hospital responses to this survey will not be made public. Only aggregate analysis will be provided in the final report. It is understood that your participation in this survey is voluntary, and that you may withdraw at any time.

Market Growth and Facility Needs

The attached profile provides a regional review of your hospital's market share and utilization with market growth projections. Additionally, a summary of interviews with city managers is provided to identify population growth expectations in the region. This survey also includes perspectives on hospital development roles and community needs for hospital development. *Please review the attached profile to address questions in this section.*

1a) When was your hospital's strategic plan last reviewed by the board/corporate?

- ❑ Over two years ago/do not know
- ❑ One - two years ago
- ❑ Within the last year - six months
- ❑ Within last six months

1b) Which phrase best describes your hospital's strategic plan & planning process?

- ❑ The strategic plan is done every 3-5 years and sits on the shelf
- ❑ The strategic plan is essentially the top 3-5 things to be done as determined by the CEO/Board Chair
- ❑ The strategic plan is reviewed annually by a planning team and incorporates goals, objectives, and actions that all have assigned responsibility (a management action plan)
- ❑ The strategic plan incorporates strategic and operational analysis, management action plan, operating budget and multi-year capital plan and is reviewed and approved by the board at least annually
- ❑ The strategic planning process includes a strategic plan with integrated management action plan tied to: A) operating budget; B) capital plan; C) master facility plan; D) management performance evaluation/bonus - and includes board reports on operating objectives (dashboards) and strategic objectives (Management Action Plan) at least quarterly

1c) Does your hospital's strategic plan incorporate the development or replacement of your hospital over the next five years?

- ❑ Yes (please go to Question **1d**)
- ❑ No (please go to Question **1e**)

1d) What was the **primary** driver for the decision to develop/replace your hospital?

(select one)

- ❑ Community/market growth
- ❑ Strategic/new program growth and development
- ❑ The facility needs renovation
- ❑ The facility needs replacement
- ❑ Other (please specify) _____

1e) What **primary condition** exists that precludes the development or replacement of your hospital?

(select one)

- ❑ We recently built/replaced/expanded the hospital
- ❑ We do not have the market share/growth to sustain new facility development.
- ❑ Competitor development
- ❑ We lack the operating performance/capital necessary for development
- ❑ Recruitment of qualified staff is a more pressing need at this time
- ❑ Other (please specify) _____

2a) Are you planning to **expand or add** new hospital services in the next two years (e.g., inpatient services, diagnostic services)?

- ❑ Yes (please describe services)_____
- ❑ No

2b) Are you planning to **reduce** existing hospital services in the next two years (e.g., inpatient, services, diagnostic services)?

- ❑ Yes (please describe services)_____
- ❑ No

3a) Which (***one***) statement in general best represents your payor mix situation/perspective?

- ❑ We consider our payor mix satisfactory/favorable
- ❑ We have implemented deliberate efforts to improve our payor mix
- ❑ We do not have a specific payor mix objective
- ❑ Trends in our payor mix are beyond our control
- ❑ Our payor mix is representative of the community we serve
- ❑ Other (please explain)_____

3b) How do you rate the following payors for hospital services?

1 - Favorable 2 - Fair 3 - Unfavorable 4 - Not Applicable

___ Traditional Medicare
___ Medicare (D/Managed)
___ Commercial/Indemnity
___ HMO/PPO Managed Care
___ Medicaid/AHCCCS
___ Other State
___ Private/Business/Occupational Med. Contracts
___ Indian Health Services
___ Other Federal

4) Which characteristics accurately describe the community's/city's/tribe's role in participating in hospital development?

(select all that apply)

- ❑ Hospital development is primarily the responsibility of the hospital
- ❑ The city plays a major role in facilitating/supporting hospital development
- ❑ There is a strong commitment of the Taxing District
- ❑ There is a questionable commitment of the Taxing District
- ❑ Our hospital has good philanthropic support from the community
- ❑ Our hospital board is the primary representation of community support
- ❑ Other (please specify) _____

5a) Please rate the following entities as to the frequency of use in assisting in planning and development of your hospital facility.

1 - Primarily/Often 2 - Occasionally 3 - Rarely/Never 4 - NA

___ IHS
___ Our internal development team
___ Strategy/facility planning consultants
___ Architects/contractors
___ Tribal leadership
___ Arizona Office of Rural Health
___ Financing entity
___ Equipment vendor

5b) Please rank from highest to lowest your strategic priorities relative to hospital development?

1 - First priority 7 - Last priority (NA- not a priority)

___ Improve operating performance
___ Identify sources of capital
___ Recruit staff
___ Build community support
___ Attain hospital board approval/buy-in
___ Develop a strategic/capital plan & financial feasibility assessment
___ Identify viable architect/contractor
___ Other (please specify)_____
___ Other (please specify)_____
___ Other (please specify)_____

6a) What do you believe is the ***one*** most important thing that the Arizona Legislature can do to facilitate ***hospital development*** in rural Arizona?

_____

_____

6b) What do you believe is the ***one*** most important thing that the Arizona Legislature can do to facilitate ***improved healthcare*** in rural Arizona?

_____

_____

HR & Technology Limitations

10) Does your hospital currently have high speed connectivity for rapid transmission of health care data?

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  _____
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_____

_____

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  _____

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❑ Three over 5 years	❑ Three over 5 years	❑ Three over 5 years
❑ Four over 5 years	❑ Four over 5 years	❑ Four over 5 years
❑ Five+ over 5 years	❑ Five+ over 5 years	❑ Five+ over 5 years

16) Rank each issue regarding your hospital facility development efforts?

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___ Difficulty in physician recruitment
___ Difficulty in nurse recruitment
___ Difficulty in recruitment of allied health staff (please specify) _____
___ Lack of access to capital/financing
___ Limited expertise in developing an strategic and financial plan
___ Facility development vs. technology development conflicts
___ Lack of expertise to assist in various areas of development process
___ Lack of community/population growth and utilization
___ Lack of support from community/civic leadership
___ Other (please specify) _____
___ Other (please specify) _____
___ Other (please specify) _____

City Manager Interview - Question 1

Which phrase best describes how the city perceives its role in hospital development?

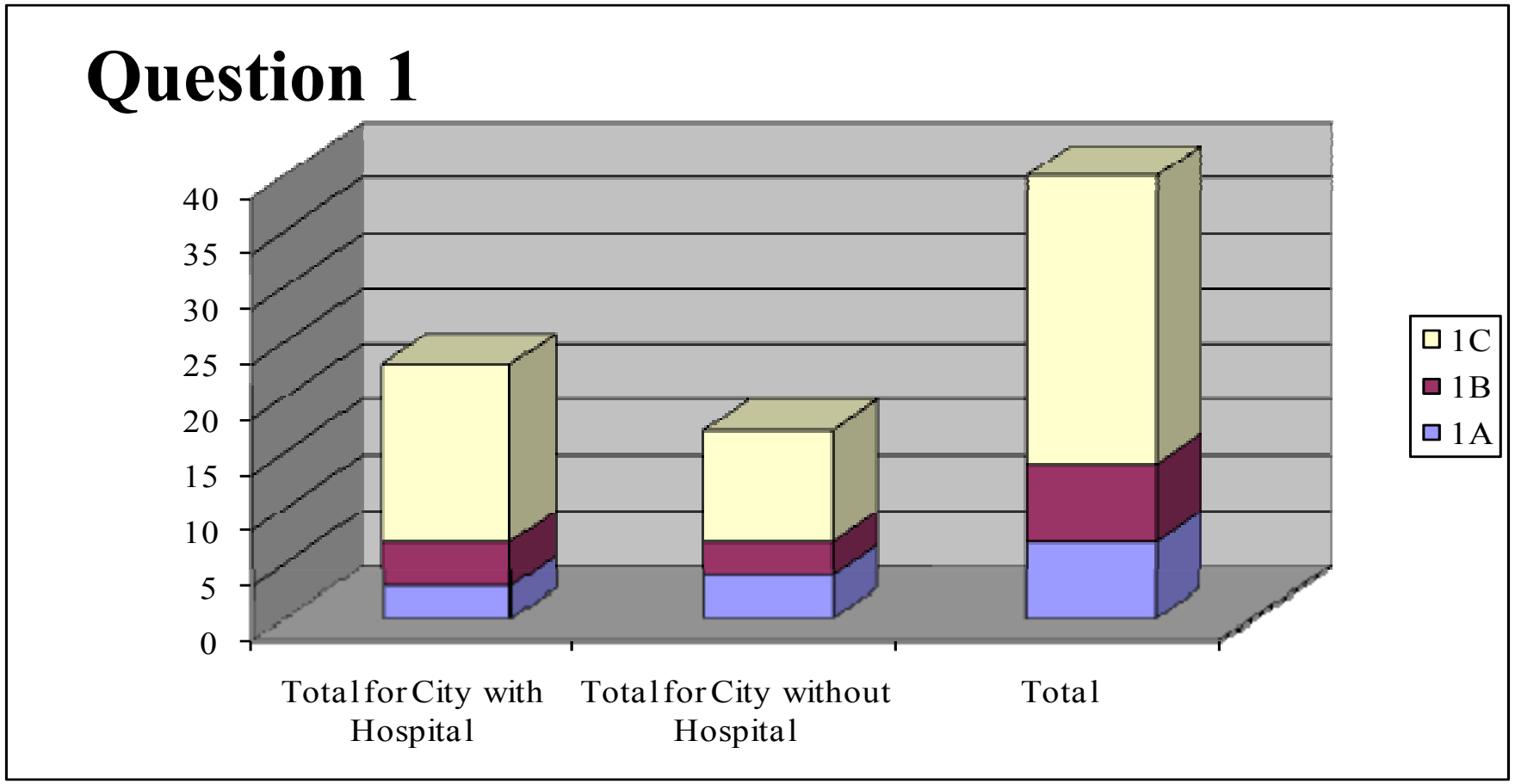
A. **Active** – it dedicates significant resources to hospital development
B. **Neutral** – it dedicates some resources to hospital development
C. **Passive** – it relies on hospital providers and developers to provide hospital services

City Manager Interview - Question 2

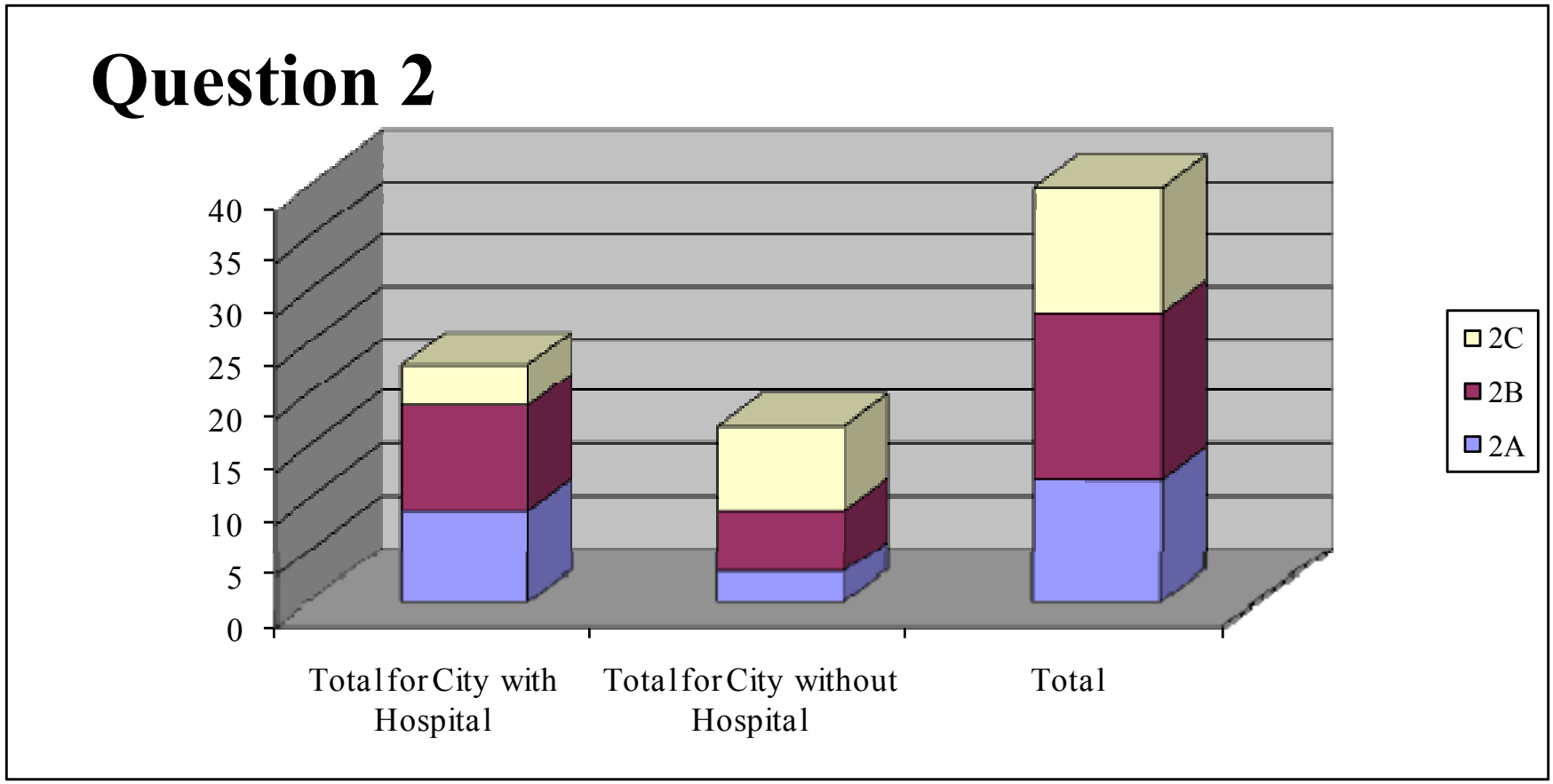
Which of the following best describes the city's/community's needs in hospital development?

A. There are **no/minimal needs** as our hospital provides for the community
B. There is a need for **education/consulting** on how to work with hospital providers to meet the community's needs
C. There is a need for **grant funding or budgeting** to determine the feasibility of hospital development

City Manager Response



City Manager Response



Interviews with City Managers

Region	City	2000 Census	Az Dept of Economic Security 2006 Estimates	Change	Rate
Region B					
	Benson	4,711	4,820	109	2.3%
	City Manager/Interviewee:	Martin Rousch			
	Acuracy of '06 AZDES Data:	Accurate			
	Growth Rate Proj. "07 -'12:	Double-5 yrs - 8K; 60K - 20 yrs			20.0%
	Notes/Developments:	600 avail. lots + 14K approved			
	Answer to Question 1:	C			
	Answer to Question 2:	A - Hospital - Hwy 90			
Region BS					
	Bisbee	6,090	6,355	265	4.4%
	City Manager/Interviewee:	John Charley			
	Acuracy of '06 AZDES Data:	1%			
	Growth Rate Proj. "07 -'12:	Accurate - 3% over 5 years - great			3.0%
	Notes/Developments:	2nd home/retire market; on hold currently; plan to annex more land; waste water dev major issue; border patrol porovides only jobs			
	Answer to Question 1:	C			
	Answer to Question 2:	B			
Region D					
	Douglas	14,312	17,660	3,348	23.4%
	City Manager/Interviewee:	Curtis Shook			
	Acuracy of '06 AZDES Data:	3-4% / year is accurate			
	Growth Rate Proj. "07 -'12:	2.7% growth expected per year			14.0%
	Notes/Developments:	80-100 units/yr; increase prison pop; 200-300 new bdg/yr; 2nd home-similar to Show Low/Pinetop			
	Answer to Question 1:	B			
	Answer to Question 2:	C			
Region SV					
	Sierra Vista	37,775	44,870	7,095	18.8%
	City Manager/Interviewee:	Jennifer Thornton			
	Acuracy of '06 AZDES Data:	3% is accurate			
	Growth Rate Proj. "07 -'12:	4% forward			20.0%
	Notes/Developments:	100% new pop - no annexation			
	Answer to Question 1:	C			
	Answer to Question 2:	A			
Region W					
	Willcox	3,733	3,910	177	4.7%
	City Manager/Interviewee:	Michael Leighton, Mgr / Christine Whelan, clerk			
	Acuracy of '06 AZDES Data:	1%			
	Growth Rate Proj. "07 -'12:	2% growth per year planned			10.0%
	Notes/Developments:	No annex; housing stagnant; low-mod income Young fam/retire; 2 apts=160+; 120 new to community			
	Answer to Question 1:	C			
	Answer to Question 2:	B			

Interviews with City Managers

Region	City	2000 Census	Az Dept of Economic Security 2006 Estimates	Change	Rate
Region PA					
	Payson	13,620	15,625	2,005	14.7%
	City Manager/Interviewee:	Ray Erlandson			
	Acuracy of '06 AZDES Data:	2%			
	Growth Rate Proj. "07 -'12:	2-2.5% a year			12.5%
	Notes/Developments:	Annexed 20-30 from subdivisions Star Valley incorporated			
	Answer to Question 1:	C			
	Answer to Question 2:	B			
	Globe	7,486	7,550	64	0.9%
	City Manager/Interviewee:	Manoj Vyas (he rescheduled three times - then unavailible)			
	Acuracy of '06 AZDES Data:				
	Growth Rate Proj. "07 -'12:				
	Notes/Developments:				
	Answer to Question 1:				
	Answer to Question 2:				
Region GR					
	No cities from list				
Region DU					
	No cities from list				
Region S					
	Safford	9,232	9,385	153	1.7%
	City Manager/Interviewee:	Huey Long			
	Acuracy of '06 AZDES Data:	Accurate			
	Growth Rate Proj. "07 -'12:	2% and 2%			2.0%
	Notes/Developments:	Morenci & Safford Mines; Freport MacMoRan (Phelps Dodge) 8 mi; 19 subdivisions app; Young semi-prof fam; 2,000 homes=6,000 pop			
	Answer to Question 1:	A			
	Answer to Question 2:	B/C - C			
	Thatcher	4,022	4,970	948	23.6%
	City Manager/Interviewee:	Heath Brown			
	Acuracy of '06 AZDES Data:	4%; 4970 - ok 2007 (SEGO 5,200)			
	Growth Rate Proj. "07 -'12:	5-7% growth yr			27.0%
	Notes/Developments:	New Copper mine (Phelps Dodge); 1st new copper mine in 30 yrs			
	Answer to Question 1:	B/C - B			
	Answer to Question 2:	B			
Region N					
	Nogales	20,878	21,765	887	4.2%
	City Manager/Interviewee:	John Kissinger			
	Acuracy of '06 AZDES Data:	Good; Accurate			
	Growth Rate Proj. "07 -'12:	Slower than past			3.0%
	Notes/Developments:	No housing development; Partnership with Holy Cross			
	Answer to Question 1:	B/C - B			
	Answer to Question 2:	B/C - B			

Interviews with City Managers

Region	City	2000 Census	Az Dept of Economic Security 2006 Estimates	Change	Rate
Southwestern Quarter					
Region WK					
	Wickenburg	5,082	6,285	1,203	23.7%
	City Manager/Interviewee:	Gary Edwards			
	Acuracy of '06 AZDES Data:	AZDES - Good; 3-4%			
	Growth Rate Proj. "07 -'12:	Low for 2012; add 1K = 2K Young family growth			25.0%
	Notes/Developments:	There was annexation; many more annexations planned Number of developments going through planning			
	Answer to Question 1:	B			
	Answer to Question 2:	B			
Region C					
	Casa Grande	25,224	38,455	13,231	52.5%
	City Manager/Interviewee:	Jim Thompson			
	Acuracy of '06 AZDES Data:	8-9%			
	Growth Rate Proj. "07 -'12:	expect 10% per year for next 5			50.0%
	Notes/Developments:	Population - >10% of growth from annexation 202 grants for hospital			
	Answer to Question 1:	C			
	Answer to Question 2:	A			
	Eloy	10,375	11,535	1,160	11.2%
	City Manager/Interviewee:	Joe Blanton			
	Acuracy of '06 AZDES Data:	2% is accurate			
	Growth Rate Proj. "07 -'12:	20%-30%			25.0%
	Notes/Developments:	2006-07 - 22% increase in prison pop 150,000 homes planned (30-40 Dev. Approved - nobody breaking ground) Robson Ranch - Age Restricted - 225/250 now; sold 300 homes Current - 14,000 - west from prison; 3 @ 1800 beds-4th @ 3000 Industry strong-800 jobs in 2 yrs lack basic services Approved (30-40) - nobody breaking ground Working on infrastructure - waste water treatment water			
	Answer to Question 1:	C			
	Answer to Question 2:	B			
	Florence	17,054	21,295	4,241	24.9%
	City Manager/Interviewee:	Himansu Patel/Jess			
	Acuracy of '06 AZDES Data:	4%			
	Growth Rate Proj. "07 -'12:	CAG - * 400 per year *2.7 over 5 years			14.0%
	Notes/Developments:	6K outside prison counts; 8K current pop. Sept. 07; no - annexation			
	Answer to Question 1:	B			
	Answer to Question 2:	C			
	Maricopa City (est. Census)	15,000	25,830	10,830	72.2%
	City Manager/Interviewee:	Danielle Casey			
	Acuracy of '06 AZDES Data:	ok			
	Growth Rate Proj. "07 -'12:	300% 50-60K (2010) 100K (2012)			300.0%
	Notes/Developments:	25,830 - 32-33K (2007);			
	Answer to Question 1:	A			
	Answer to Question 2:	C			
Region CR					
	No cities from list				

Interviews with City Managers

Region	City	2000 Census	Az Dept of Economic Security 2006 Estimates	Change	Rate

Region GB

No cities from list

Region Y

	San Luis	15,322	23,710	8,388	54.7%
City Manager/Interviewee:	Jeffrey Philpot				
Acuracy of '06 AZDES Data:	9% is accurate				
Growth Rate Proj. "07 -'12:	2007-2012 - 50K by 2010 - 2012 60K+				300.0%
Notes/Developments:	No annexation - All pop; 1,200 homes approved currently				
	In winter - Snow Birds / Agriculture (Illegals/workers-Double); limited water/sewer capacity				
	This year -9K homes - no impact of housing downtown				
Answer to Question 1:	C				
Answer to Question 2:	C				

	Somerton	7,266	10,100	2,834	39.0%
City Manager/Interviewee:	Cliff O'Neil				
Acuracy of '06 AZDES Data:	6-7% is accurate				
Growth Rate Proj. "07 -'12:	Future - 200 houses a year is consistent				50.0%
Notes/Developments:	$3,000 grant - under 40 - young family				
	Becoming bedroom community for Yuma				
	Moving in - air station, Border Patrol, Customs employees				
Answer to Question 1:	C				
Answer to Question 2:	C				

	Yuma	77,515	92,160	14,645	18.9%
City Manager/Interviewee:	Mark Watson				
Acuracy of '06 AZDES Data:	3% 92,160 - not correct closer to 93,000				
Growth Rate Proj. "07 -'12:	5% year - 2012 looks ok				25.0%
Notes/Developments:	Annexation of population - Yes, some				
Answer to Question 1:	C				
Answer to Question 2:	A				

Region TO

No cities from list

Region P

	Parker	3,140	3,270	130	4.1%
City Manager/Interviewee:	Guy Gorman				
Acuracy of '06 AZDES Data:	4% is accurate				
Growth Rate Proj. "07 -'12:	.7% to 1% per year				4.0%
Notes/Developments:	Land-locked by Tribal lands				
	Current annexation will not increase population				
	187 units planned over the next 4 years				
Answer to Question 1:	B/C - C				
Answer to Question 2:	A				

Interviews with City Managers

Region	City	2000 Census	Az Dept of Economic Security 2006 Estimates	Change	Rate
Northern Half					
Region F					
	Flagstaff	52,894	62,030	9,136	17.3%
	City Manager/Interviewee:	Jim Wine			
	Acuracy of '06 AZDES Data:	2-3%			
	Growth Rate Proj. "07 -'12:	Historical 3% per year			14.0%
	Notes/Developments:	DES Pop Tax-schools/group hm counts low; No annex; 18-44 pop-college/young; 3K houses planned/possible 5K by 2020; 500 units broke ground -200 by 2012 Target-traditional neighborhood design			
	Answer to Question 1:	C			
	Answer to Question 2:	B			
	Williams	2,842	3,170	328	11.5%
	City Manager/Interviewee:	Harry Holmes			
	Acuracy of '06 AZDES Data:	1-2% is accurate			
	Growth Rate Proj. "07 -'12:	Past OK 2% - maybe less until selling "happens"?			7.0%
	Notes/Developments:	Vacant "Luxury lots"/houses; 500-600 hms & 70 more; theme Park-2 yrs out (when and if) Have clinic - does nice job; retirement			
	Answer to Question 1:	C			
	Answer to Question 2:	A			
Region NC					
	Colorado City	3,334	4,050	716	21.5%
	City Manager/Interviewee:	Dave Darger			
	Acuracy of '06 AZDES Data:	Accurate 3% growth			
	Growth Rate Proj. "07 -'12:	2-3% future			14.0%
	Notes/Developments:				
	Answer to Question 1:	C			
	Answer to Question 2:	A			
Region NCR					
	Page	6,809	7,230	421	6.2%
	City Manager/Interviewee:	Bo Thomas / Lona			
	Acuracy of '06 AZDES Data:	Yes			
	Growth Rate Proj. "07 -'12:	same			6.0%
	Notes/Developments:	None			
	Answer to Question 1:	A			
	Answer to Question 2:	A			
Region CT					
	Sedona	2,963	3,125	162	5.5%
	Sedona	7,229	7,885	656	9.1%
	City Manager/Interviewee:	Eric Levitt			
	Acuracy of '06 AZDES Data:	Accurate			
	Growth Rate Proj. "07 -'12:	1% - 2%			7.0%
	Notes/Developments:	2 lg condo 240 = 88 retirement-1.7 over 55 750K; 2000 sq ft 160 = PT/second homes Sm growth rate; emergency rm; no past/future annex			
	Answer to Question 1:	C			
	Answer to Question 2:	C			

Interviews with City Managers

Region	City	2000 Census	Az Dept of Economic Security 2006 Estimates	Change	Rate
	Camp Verde	9,451	11,230	1,779	18.8%
	City Manager/Interviewee:	Nancy Buckle			
	Acuracy of '06 AZDES Data:	3%			
	Growth Rate Proj. "07 -'12:	3% a year - subdivision came in			15.0%
	Notes/Developments:	moderate range homes-$200,000 or lower 341-ready for development; 252-need sewer 660 - 1 master planned			
	Answer to Question 1:	C - Passive - rely on Cottonwood			
	Answer to Question 2:	B - Education/consulting			
	Cottonwood	9,179	10,925	1,746	19.0%
	City Manager/Interviewee:	Marianne Jimenez / George Gellard / KC Rooney			
	Acuracy of '06 AZDES Data:	5% a year is accurate			
	Growth Rate Proj. "07 -'12:	same - 5% a year			20.0%
	Notes/Developments:	Verde Santa Fe - 2,000 residents in next 2 years Mesquite Hills - being planned			
	Answer to Question 1:	C			
	Answer to Question 2:	B			
Region PS					
	Chino Valley	7,835	12,700	4,865	62.1%
	City Manager/Interviewee:	Bill Pupo			
	Acuracy of '06 AZDES Data:	Accurate Growth of 10%			
	Growth Rate Proj. "07 -'12:	8% - 10%			45.0%
	Notes/Developments:	Many commuters moving in			
	Answer to Question 1:	A			
	Answer to Question 2:	C			
	Prescott	33,938	42,085	8,147	24.0%
	City Manager/Interviewee:	Jane Bristol			
	Acuracy of '06 AZDES Data:	Low in '06 - 44,000 - 4%			
	Growth Rate Proj. "07 -'12:	No big development - 2%-3%			12.0%
	Notes/Developments:	Prescott - VA - 2 specialty surgical hospitals			
	Answer to Question 1:	C			
	Answer to Question 2:	A			
	Prescott Valley	23,535	35,740	12,205	51.9%
	City Manager/Interviewee:	Larry Tarkowski			
	Acuracy of '06 AZDES Data:	9%			
	Growth Rate Proj. "07 -'12:	6-7%; 2025 - 75K - 2012			30.0%
	Notes/Developments:	No annexed population 2012 projection = 47K/4!48K addition			
	Answer to Question 1:	A - Did needs study-provided financial asst.			
	Answer to Question 2:	A			
	Snowflake	4,460	5,180	720	16.1%
	City Manager/Interviewee:	Mr. Call/Deniese Cox			
	Acuracy of '06 AZDES Data:	Accurate			
	Growth Rate Proj. "07 -'12:	same			16.0%
	Notes/Developments:				
	Answer to Question 1:	C			
	Answer to Question 2:	A			

Interviews with City Managers

Region	City	2000 Census	Az Dept of Economic Security 2006 Estimates	Change	Rate
	Taylor	3,176	4,270	1,094	34.4%
	City Manager/Interviewee:	Eric Duthie			
	Acuracy of '06 AZDES Data:	Accurate 6% - 6% Stable (possibly higher growth)			
	Growth Rate Proj. "07 -'12:	5-6%			28.0%
	Notes/Developments:	"The Next Prescott"			
	Answer to Question 1:	A			
	Answer to Question 2:	C			
Region SL					
	Eagar	4,033	4,530	497	12.3%
	City Manager/Interviewee:	Bill Greenwood			
	Acuracy of '06 AZDES Data:	Projections are accurate - most growth over last two years			
	Growth Rate Proj. "07 -'12:	project 2-3% into next 5 years			12.0%
	Notes/Developments:	land less expensive than show low			
	Answer to Question 1:	B			
	Answer to Question 2:	C			
	Springerville	1,972	2,125	153	7.8%
	City Manager/Interviewee:	Larisa Bogardus			
	Acuracy of '06 AZDES Data:	1-2% Growth is accurate			
	Growth Rate Proj. "07 -'12:	3-4%			15.0%
	Notes/Developments:	22 Apartments 47 New Housing Units			
	Answer to Question 1:	C			
	Answer to Question 2:	B			
	Saint Johns	3,269	3,925	656	20.1%
	City Manager/Interviewee:	Dana Overson			
	Acuracy of '06 AZDES Data:	Data ok - plan 4% growth estimate			
	Growth Rate Proj. "07 -'12:	3-4%			18.0%
	Notes/Developments:	Construction on 6 developments = 2,000 new pop No pop from 01/02 Annex New 20 bed asst living facility in '07			
	Answer to Question 1:	C			
	Answer to Question 2:	B			
	Pinetop-Lakeside	3,582	4,540	958	26.7%
	City Manager/Interviewee:	Kelly Udall			
	Acuracy of '06 AZDES Data:	Accurate			
	Growth Rate Proj. "07 -'12:	4%			20.0%
	Notes/Developments:	No population annexed; serv pop doubles in summer; many second homes; 12 develements being planned; forest service land exchange in works			
	Answer to Question 1:	C			
	Answer to Question 2:	A/B - B			
	Show Low	7,695	10,555	2,860	37.2%
	City Manager/Interviewee:	Ed Muder - Secretary			
	Acuracy of '06 AZDES Data:	Is Accurate			
	Growth Rate Proj. "07 -'12:	6%			30.0%
	Notes/Developments:	3,500 new/second homes/20 yrs; high vacancy rate 100% new pop - no annexed pop; 2007-11,473 projection			
	Answer to Question 1:	C			
	Answer to Question 2:	A			

Interviews with City Managers

Region	City	2000 Census	Az Dept of Economic Security 2006 Estimates	Change	Rate
Region BC					
	Bullhead City	33,769	39,930	6,161	18.2%
	City Manager/Interviewee:	Jim Ernster			
	Acuracy of '06 AZDES Data:	3% 40K is low/43K current			
	Growth Rate Proj. "07 -'12:	3% may decrease - 1% for this year and next-due to housing			13.0%
	Notes/Developments:	99% pop growth; no annex; 71K future-way low 63K low for region; closer to 85K; 400 permits/yr			
	Answer to Question 1:	C			
	Answer to Question 2:	B			
Region K					
	Kingman	20,069	27,635	7,566	37.7%
	City Manager/Interviewee:	Jack Kramer			
	Acuracy of '06 AZDES Data:	6%			
	Growth Rate Proj. "07 -'12:	6% Growth - continue			30.0%
	Notes/Developments:				
	Answer to Question 1:	C			
	Answer to Question 2:	C			
Region LH					
	Lake Havasu City	41,938	54,610	12,672	30.2%
	City Manager/Interviewee:	Charlie Cassens			
	Acuracy of '06 AZDES Data:	may be light 55k-65k currently			
	Growth Rate Proj. "07 -'12:	3% to 4% per year over next five years			18.0%
	Notes/Developments:	Many people moving from Sothern California Many homes are secondary residence			
	Answer to Question 1:	C			
	Answer to Question 2:	A/B - B			
Region HO					
	Holbrook	4,917	5,455	538	10.9%
	City Manager/Interviewee:	Akos Kovach			
	Acuracy of '06 AZDES Data:	2% year			
	Growth Rate Proj. "07 -'12:	10% over next 5 years			10.0%
	Notes/Developments:	3 housing dev - in excess of 1000 units total Industrial/transportation growth focus Fedex just set up transfer station			
	Answer to Question 1:	A			
	Answer to Question 2:	B			
	Winslow	9,520	9,945	425	4.5%
	City Manager/Interviewee:	Paul Ferris			
	Acuracy of '06 AZDES Data:	It is accurate			
	Growth Rate Proj. "07 -'12:	Projecting 3% over next five years			3.0%
	Notes/Developments:	763 Units in development (703 homes and 60 Appts.) over 5 - 10 years 200 acre property being evaluated for potential development			
	Answer to Question 1:	B			
	Answer to Question 2:	C			
Region KR					
	No cities on list				

Interviews with City Managers

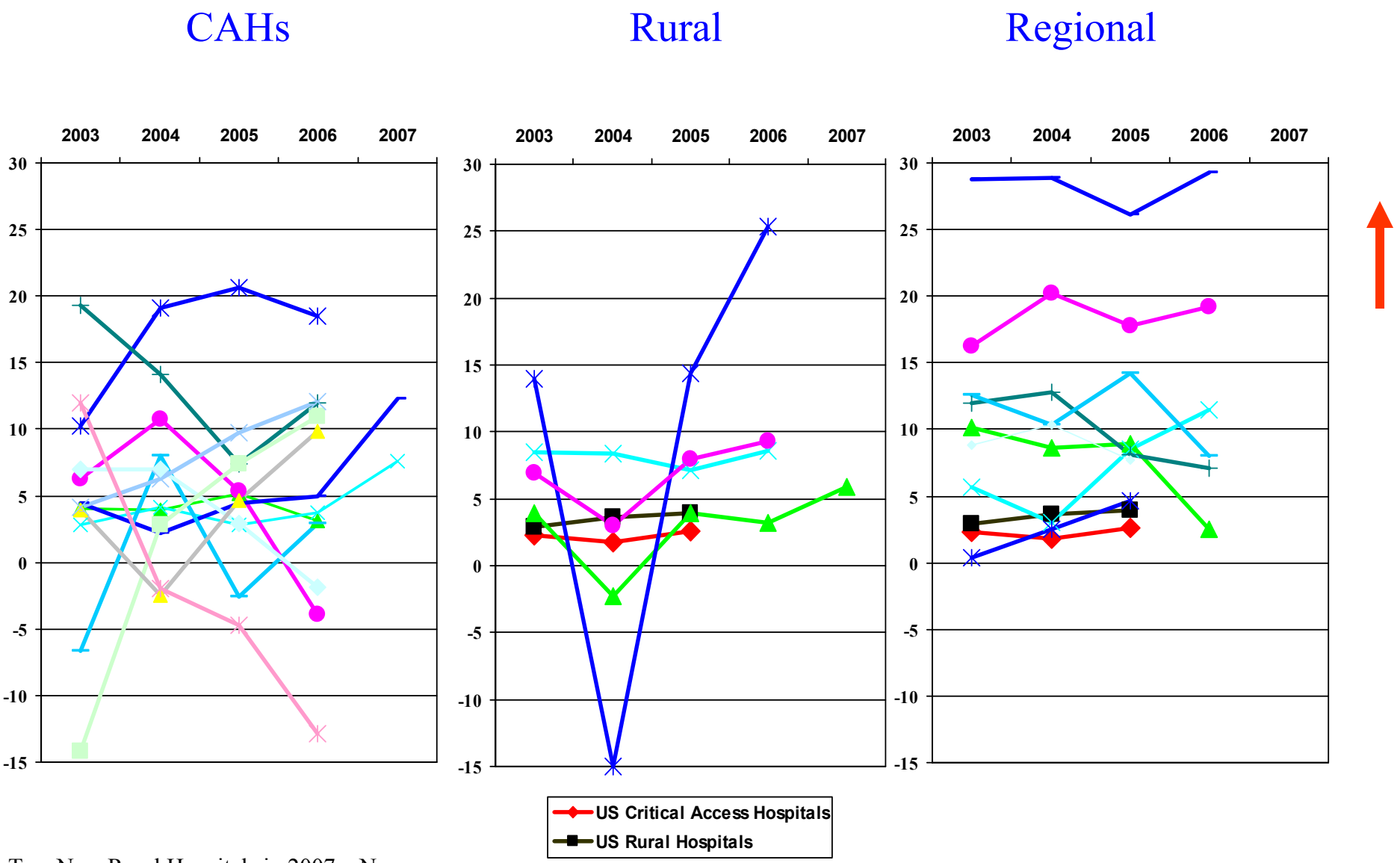
Region	City	2000 Census	Az Dept of Economic Security 2006 Estimates	Change	Rate
Region FR Navajo					
	No cities on list				
Region FR Havasupai					
	No cities on list				

Appendix G

Rural Need over next five years due to projected population growth

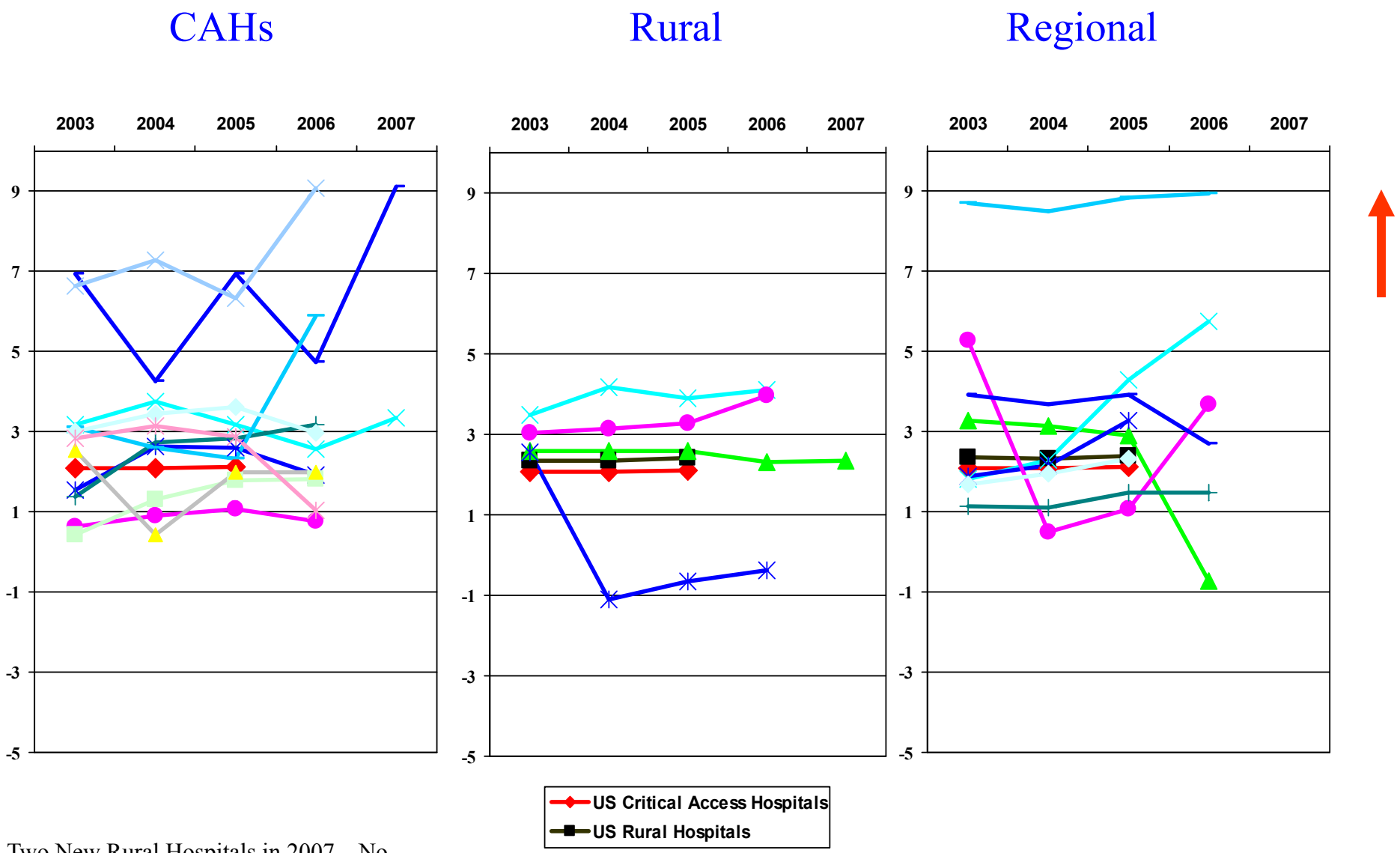
Region	Physician Need	Bed Need	Region	Physician Need	Bed Need
Casa Grande	50.71	48.38	GR San Carlos	0.70	3.07
Yuma	76.52	33.74	Nogales	2.48	1.86
Region PS - Prescott	28.58	27.58	Region B - Benson	2.41	1.69
Region CT - Cottonwood	13.21	24.09	Region WK - Wickenburg	1.98	1.53
Region K - Kingman	11.31	20.42	Region W - Willcox	1.77	1.51
Region BC - Bullhead City	9.96	16.17	Region G - Globe	4.15	1.49
Region C - Gila Bend	8.60	14.61	Region CR Gila River	0.59	0.89
Region F - Flagstaff	14.07	14.55	Region DU - Dudleyville	2.44	0.85
Region SL - Show Low	13.72	12.34	Region PG - Page	0.47	0.72
Region LH - Lake Havasu	14.13	11.70	Region BS - Bisbee	0.25	0.70
Region SV - Sierra Vista	10.08	11.52	Region KR Hualapai	0.19	0.33
Region FR Navajo/ Hopi	7.76	9.71	Region HO - Holbrook	1.77	0.20
Region PA - Payson	2.98	8.16	Region NC - North Canyon	1.89	0.15
Region S - Safford	2.16	4.17	Region FR Havasupai	0.00	-0.06
Region P - Parker	1.42	3.50	Region TO - Tohono O'odham	-0.09	-1.79
Region D - Douglas	2.66	3.12	**TOTAL**	**289**	**277**

Profitability - Total Margin



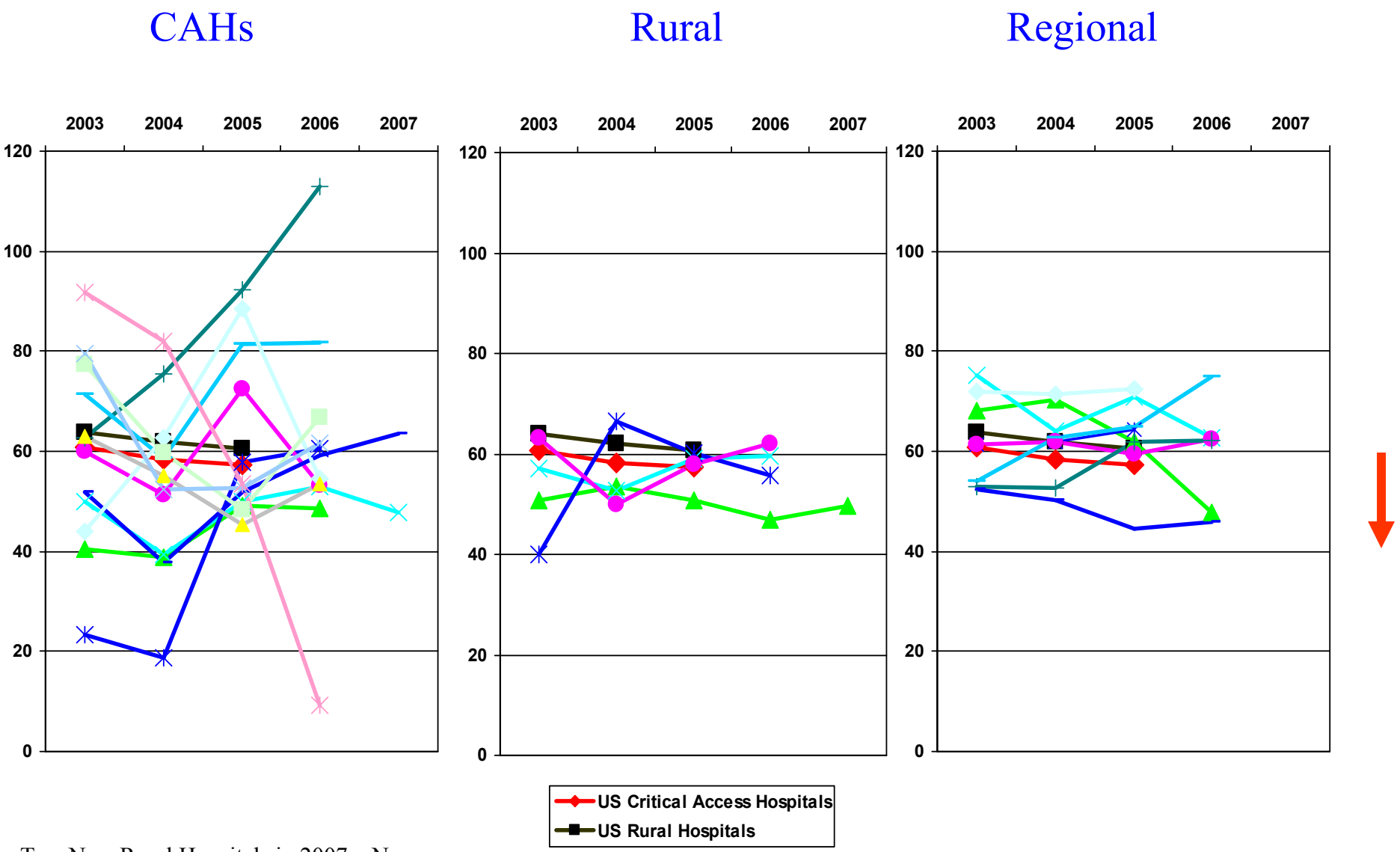
Two New Rural Hospitals in 2007 – No Available Data

Liquidity – Current Ratio



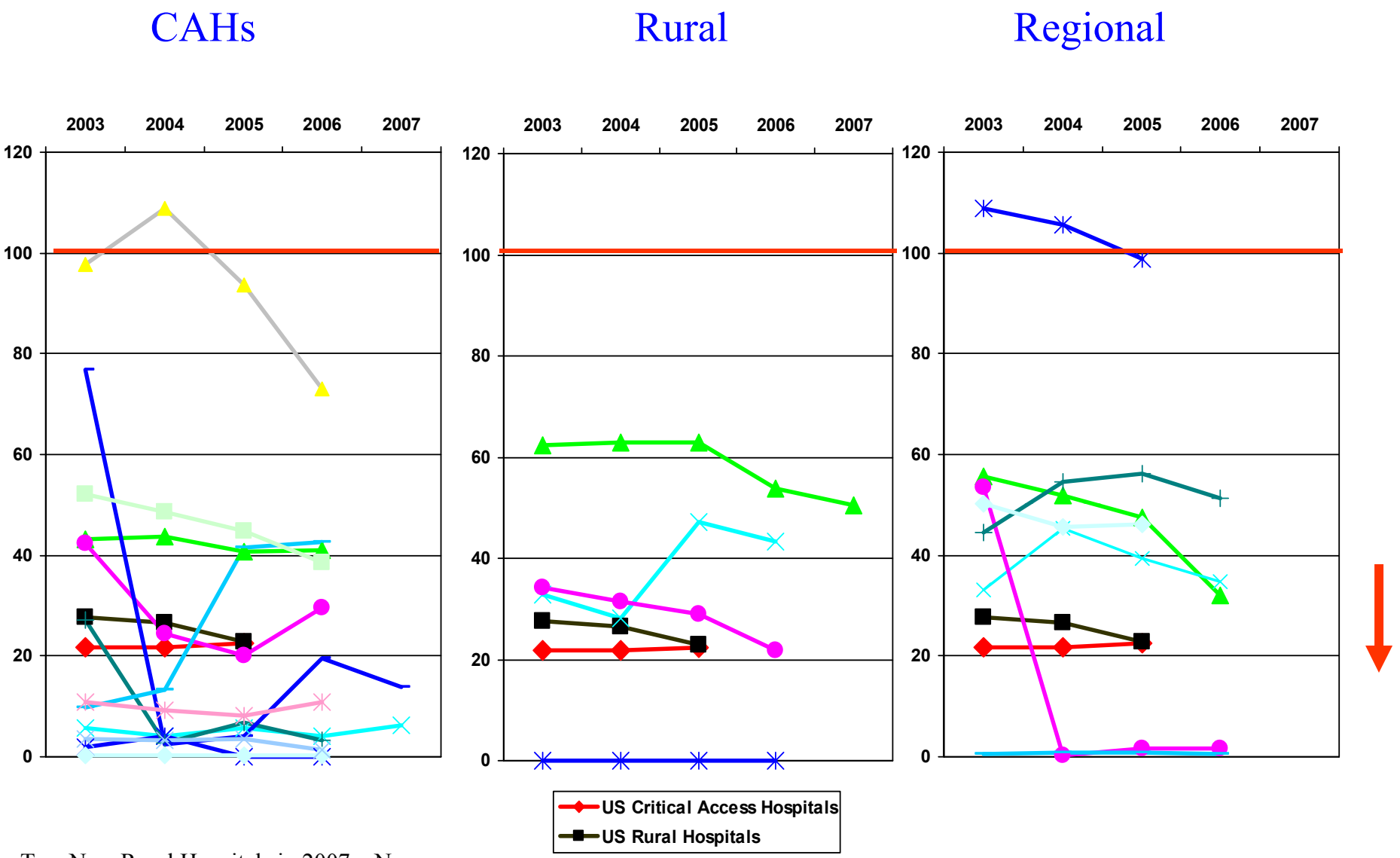
Two New Rural Hospitals in 2007 – No Available Data

Liquidity – Net Days Revenue in Accounts Receivable



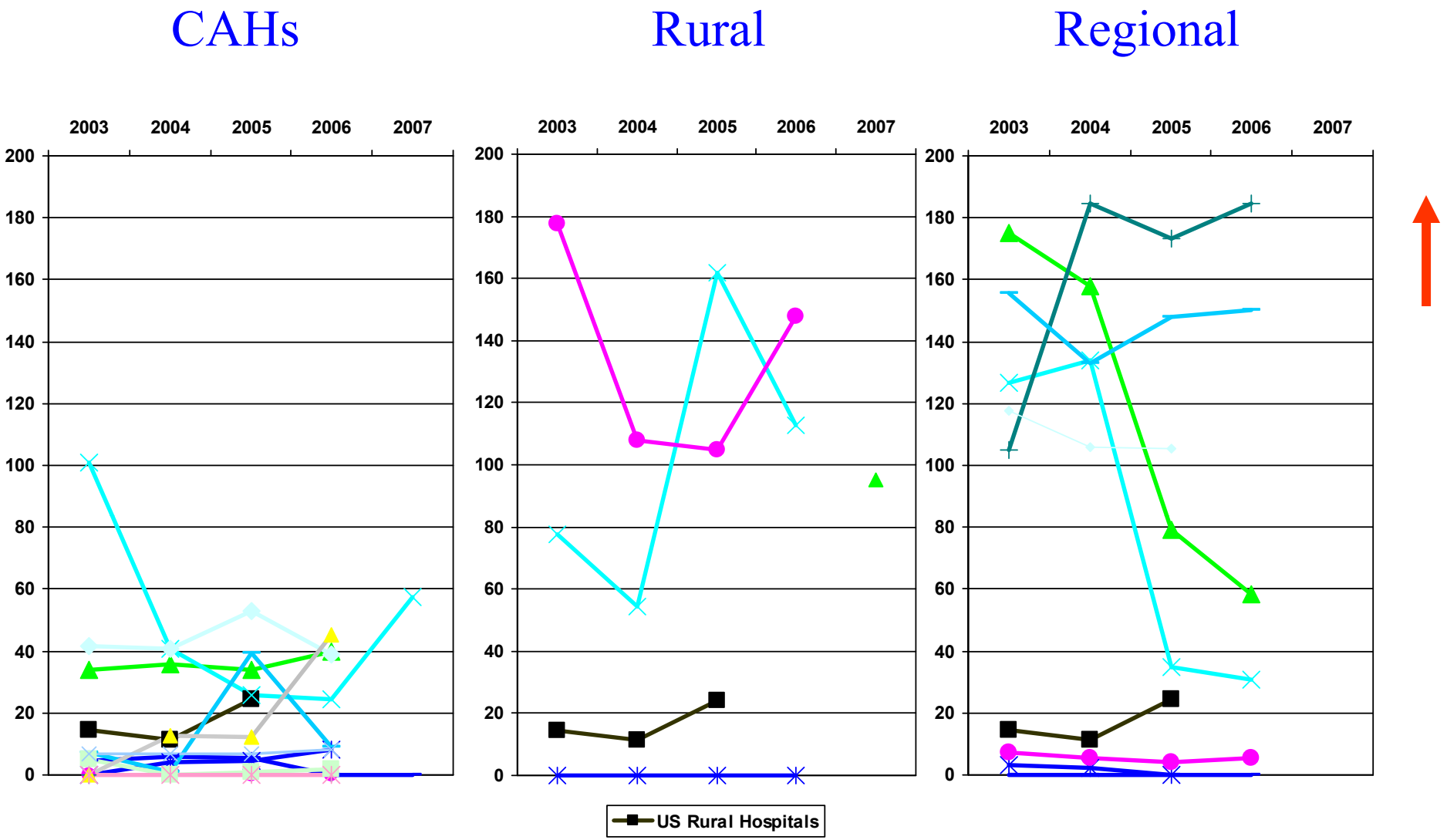
Two New Rural Hospitals in 2007 – No Available Data

Capital Structure – Long-term Debt to Capitalization



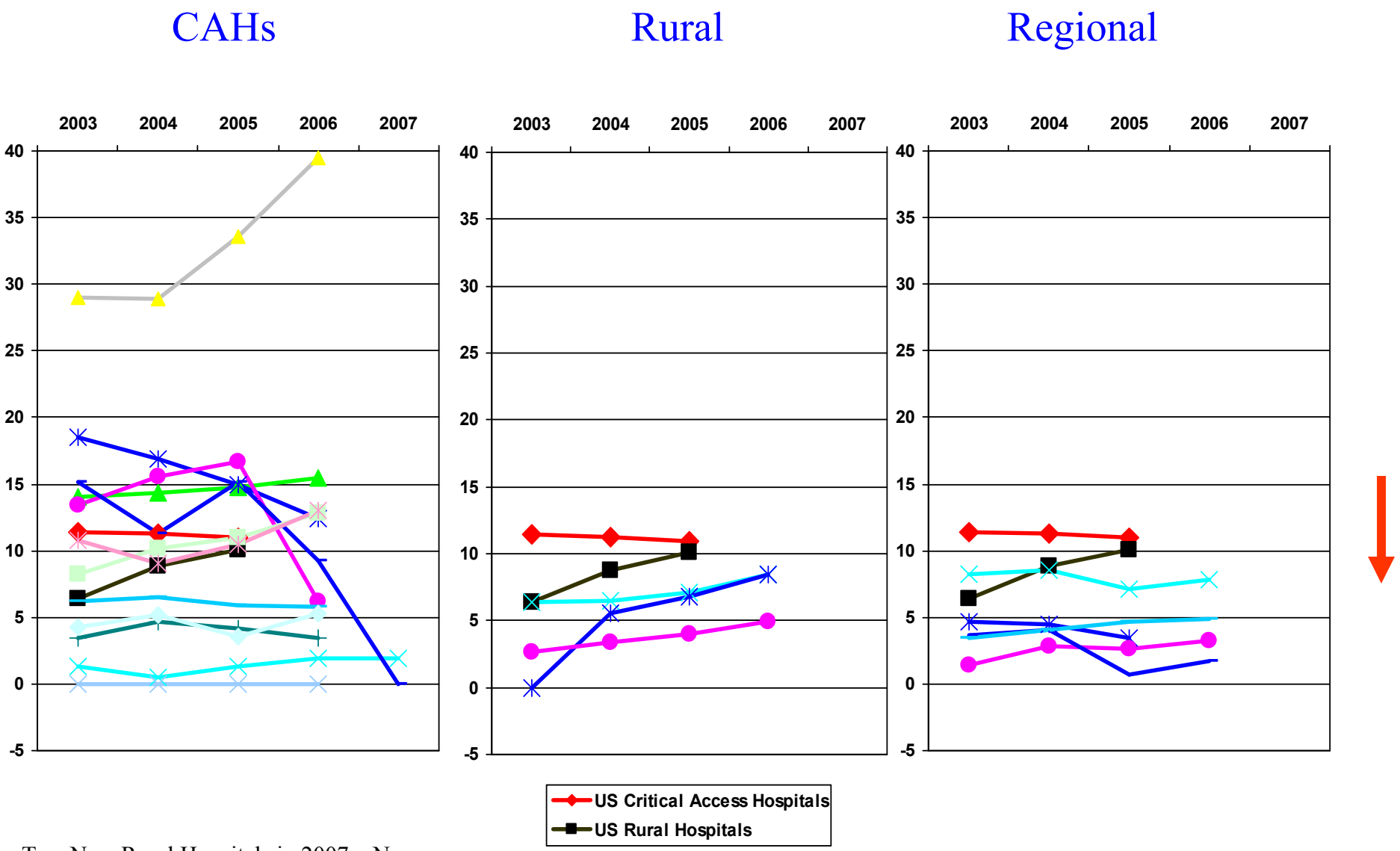
Two New Rural Hospitals in 2007 – No Available Data

Facility Indicators – Replacement Viability



Two New Rural Hospitals in 2007 – No Available Data

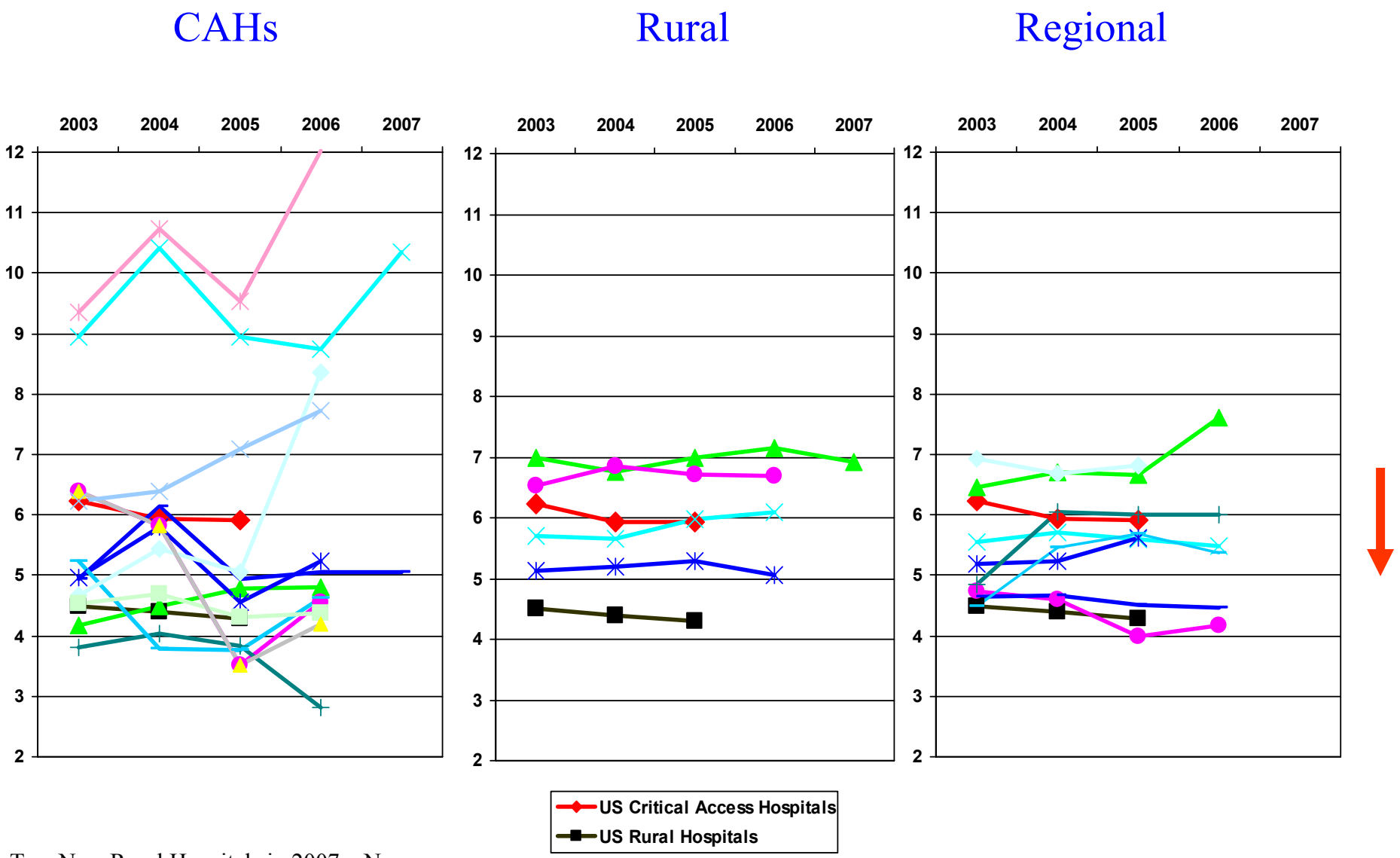
Facility – Average Age of Plant



Two New Rural Hospitals in 2007 – No Available Data

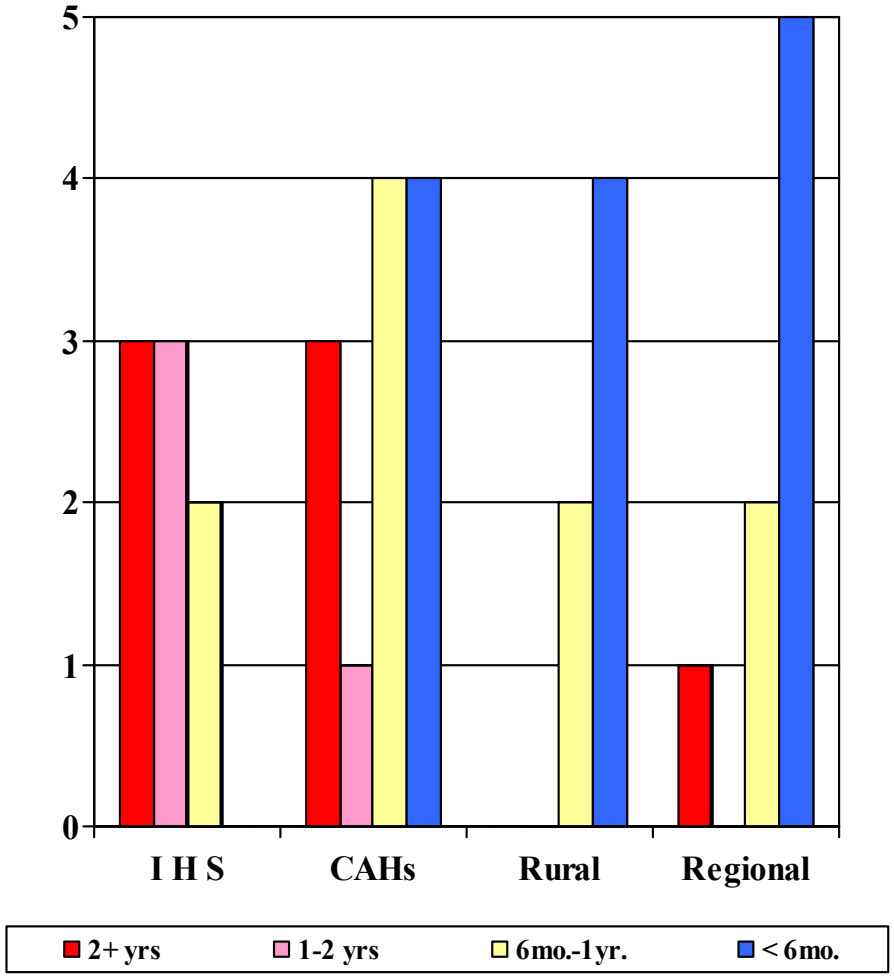
Appendix N

Utilization – FTEs / Adjusted Occupied Bed

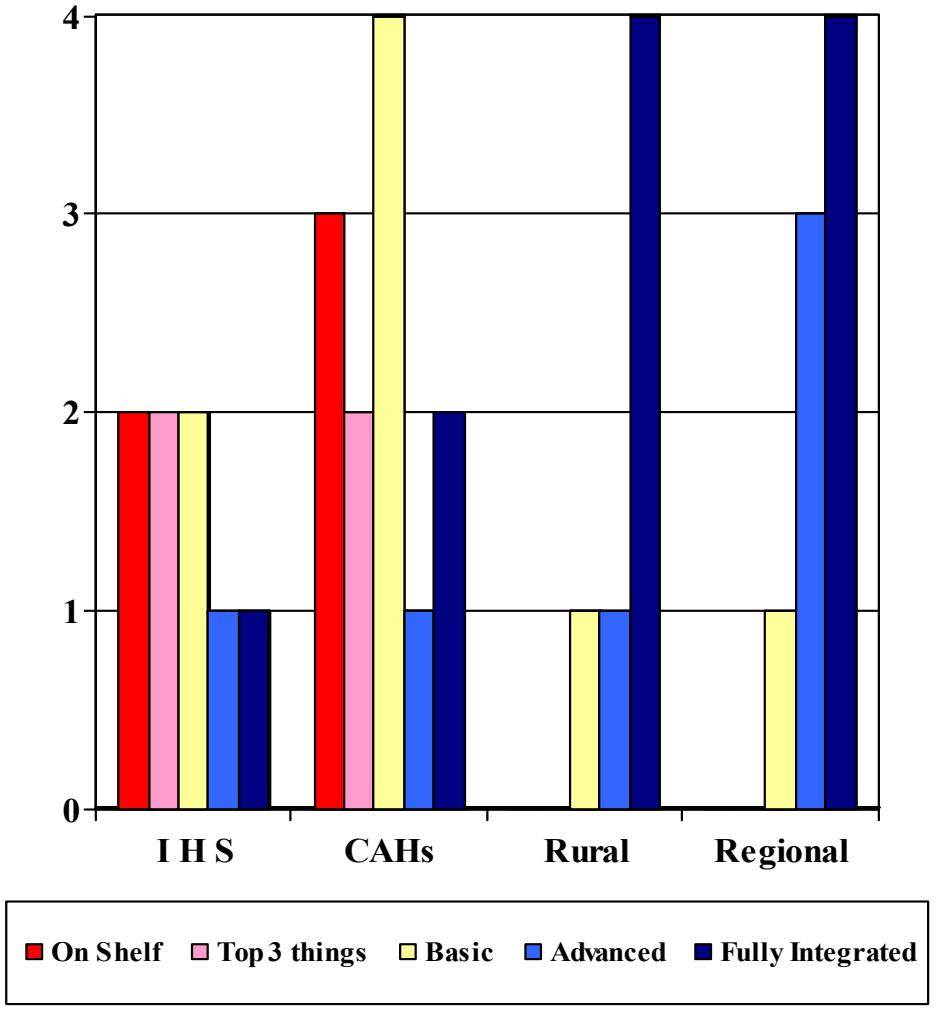


Two New Rural Hospitals in 2007 – No Available Data

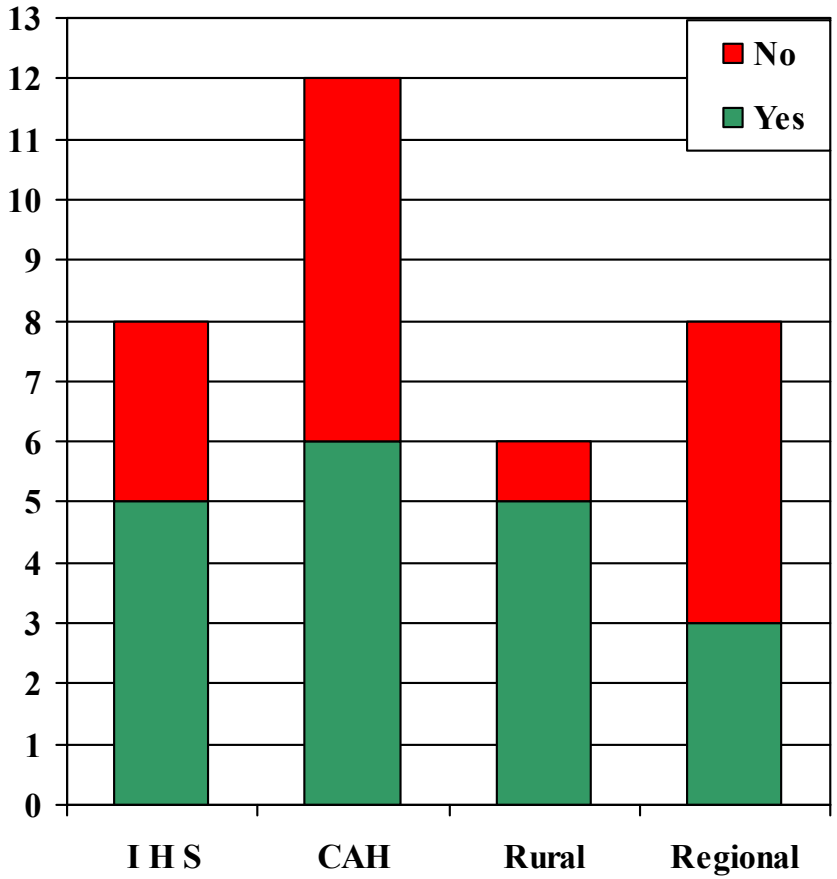
When was your Strategic Plan last reviewed?



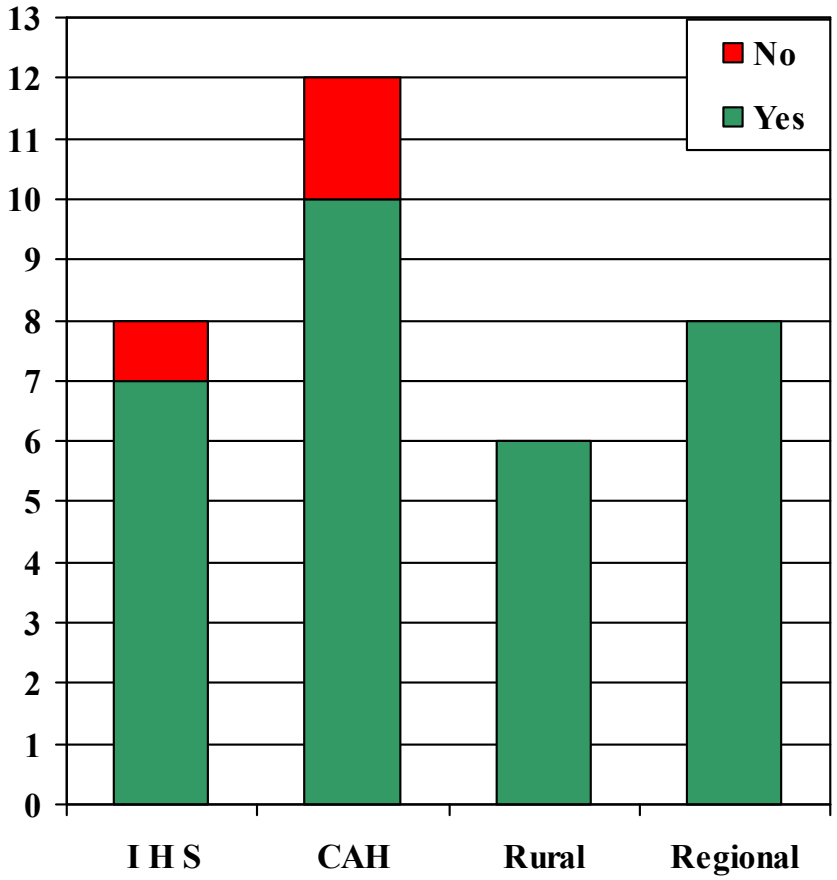
What is included in strategic planning process and frequency of review?



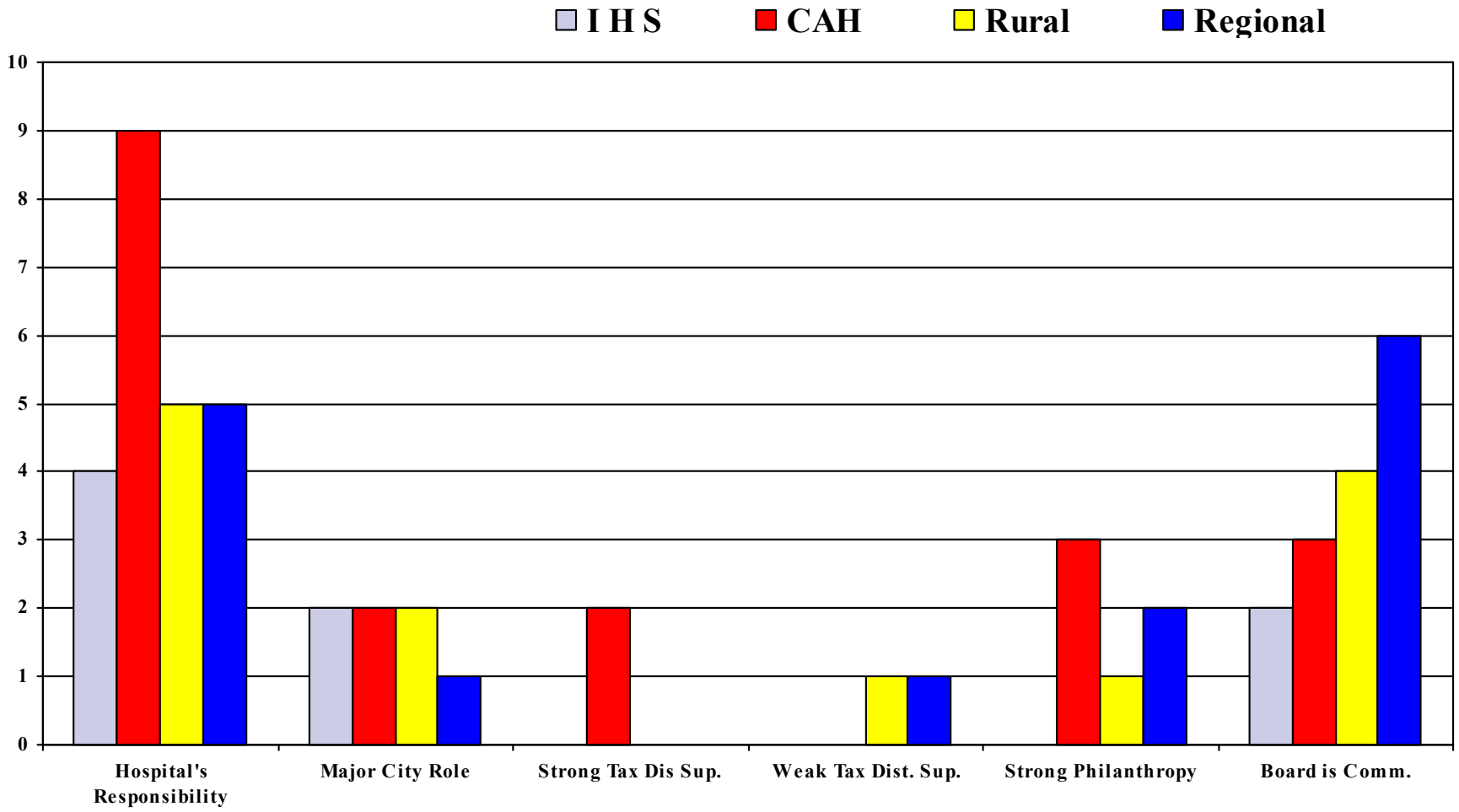
Does your Hospital's strategic plan incorporate the development or replacement of the Hospital over the next 5 years?



Are you planning to expand or add new hospital services within two years?

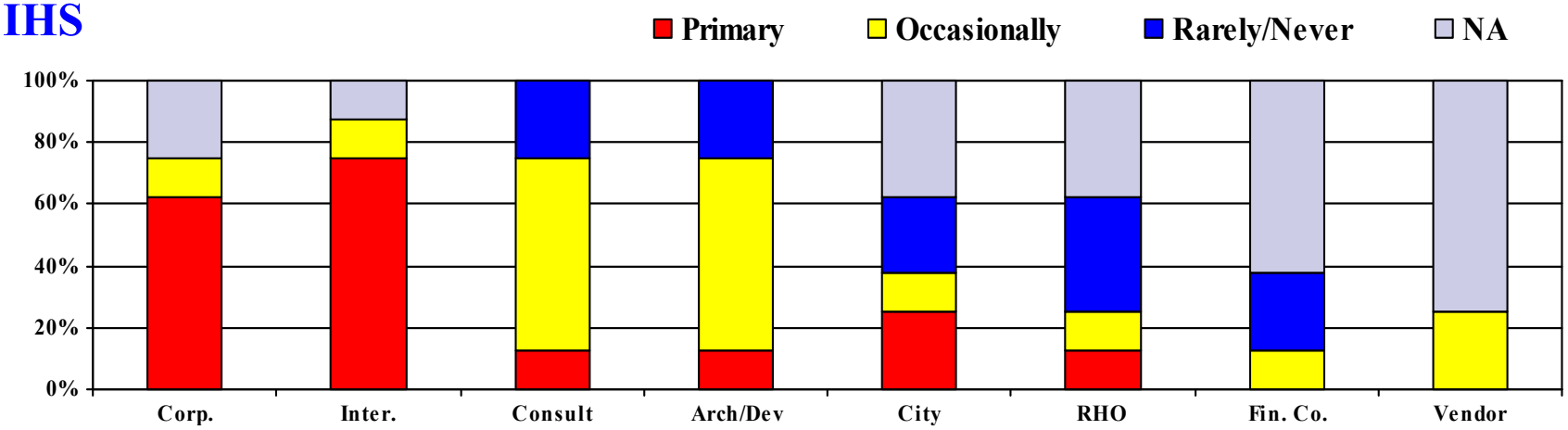


Which characteristics accurately describe the community's/city's /tribe's role in participating in hospital development?

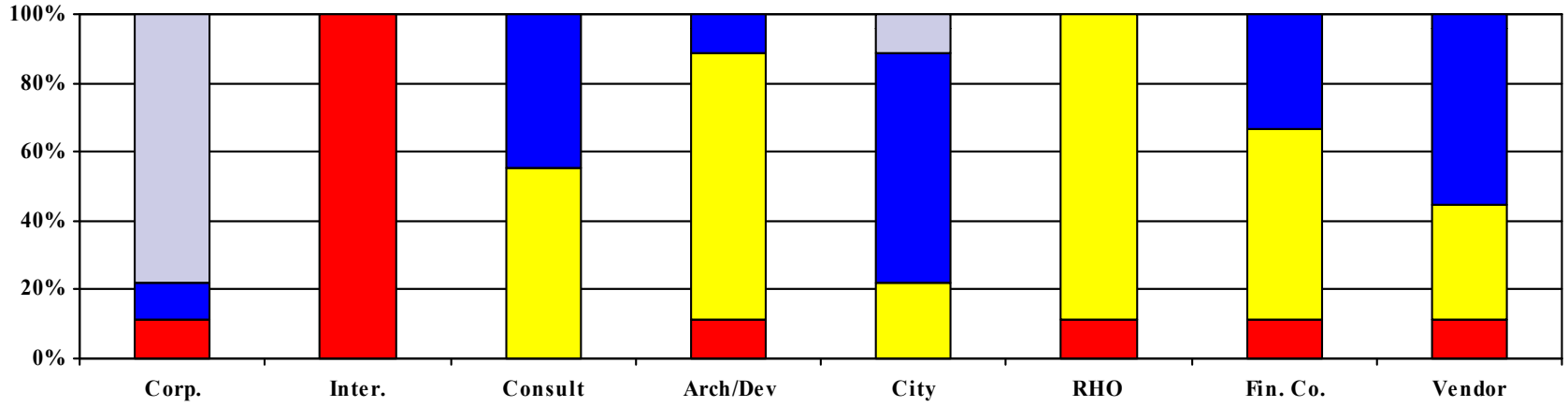


Rate the following entities as to the frequency of use in assisting in the planning and development of your hospital facility.

IHS

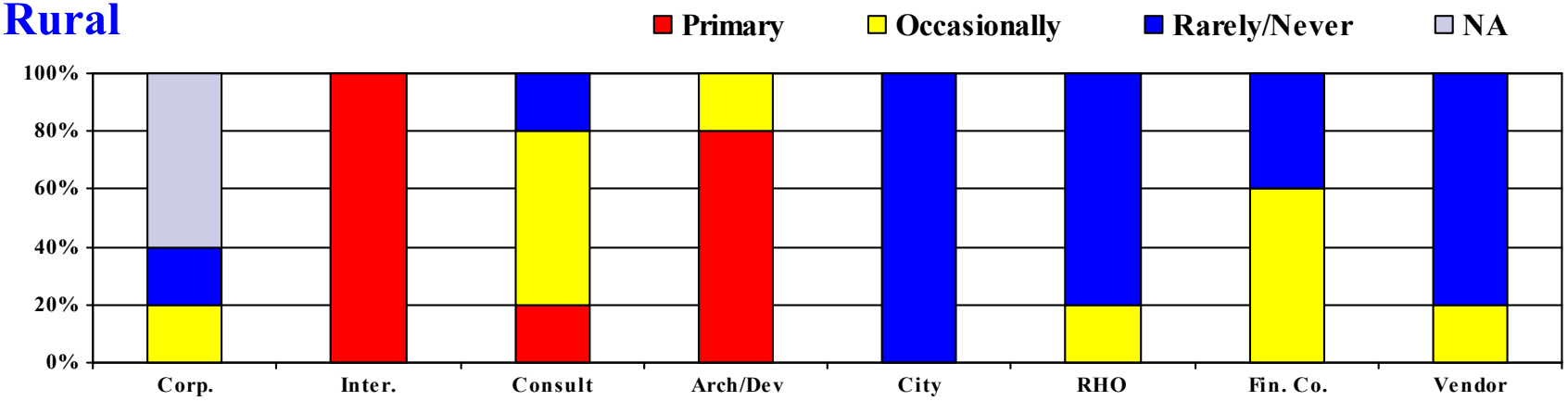


CAHs

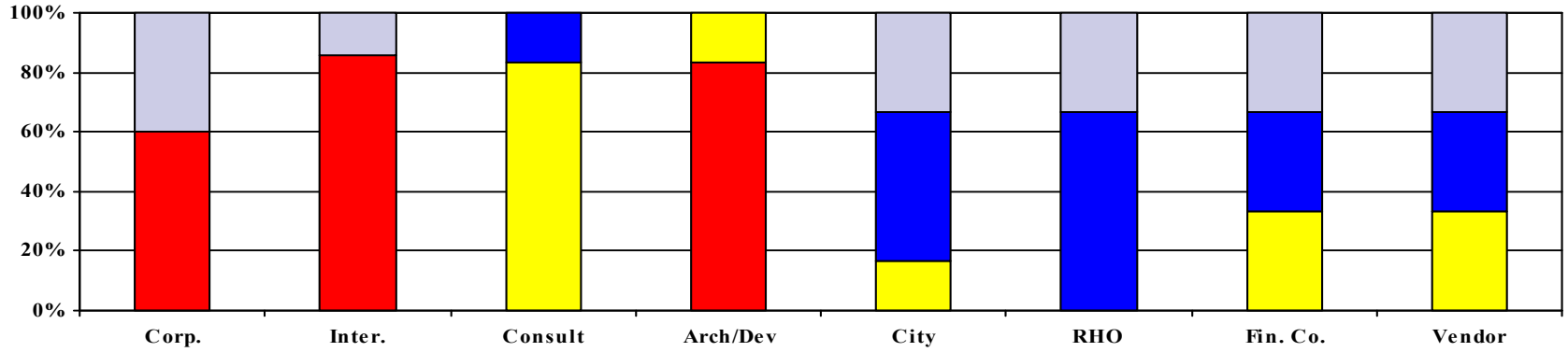


Rate the following entities as to the frequency of use in assisting in the planning and development of your hospital facility.

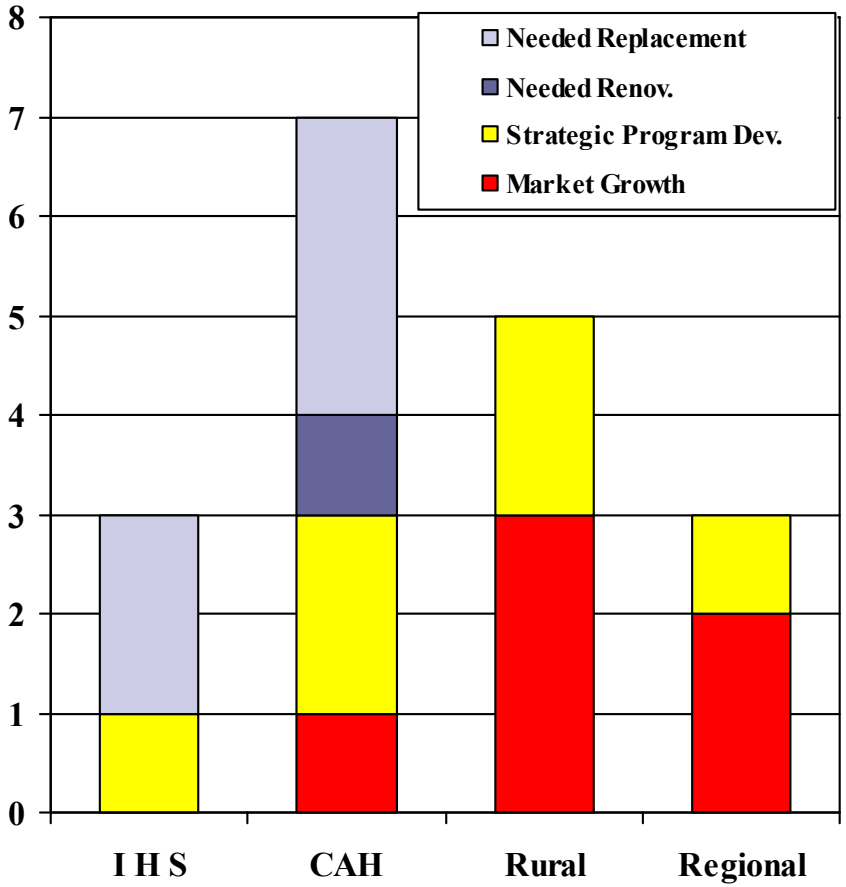
Rural



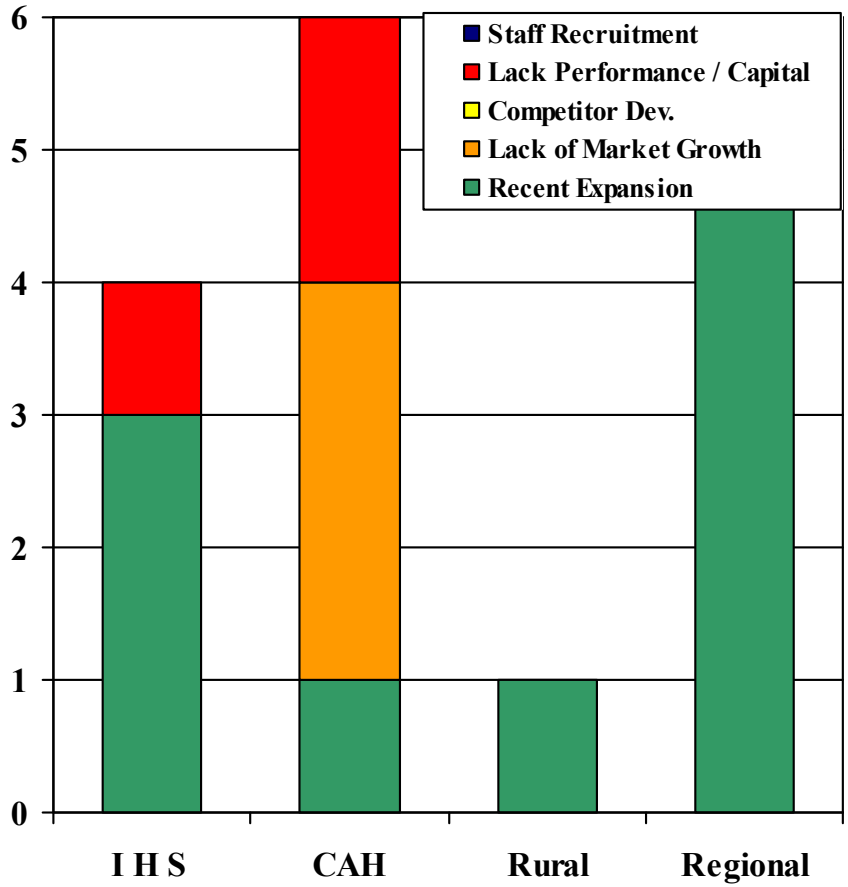
Regional



What is the primary driver for the decision to development or replace the hospital?

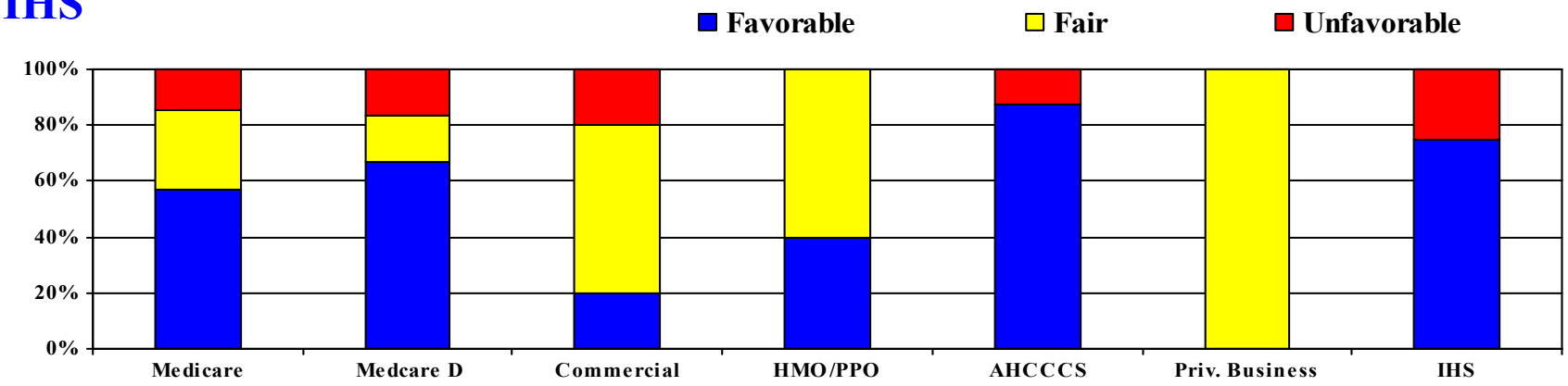


What primary condition exists that precludes the development or replacement of your hospital?

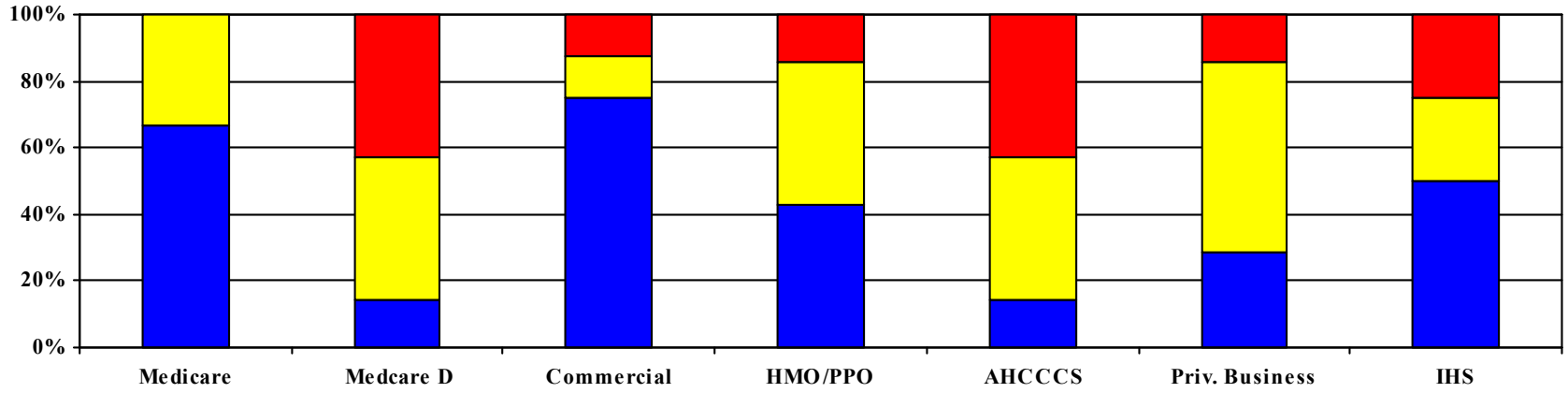


How do you rate the following payors for hospital services?

IHS

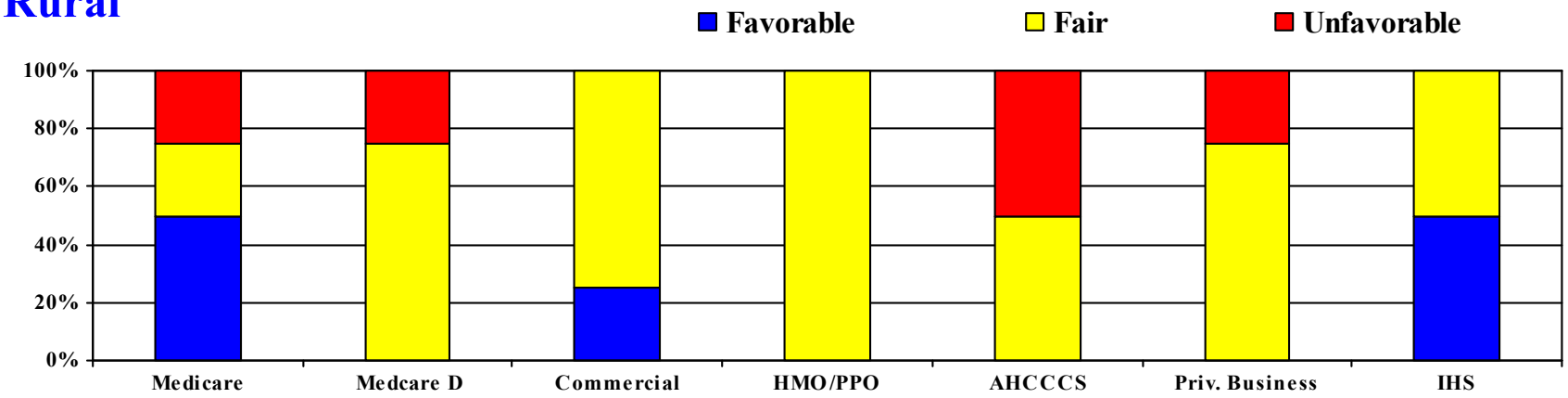


CAHs

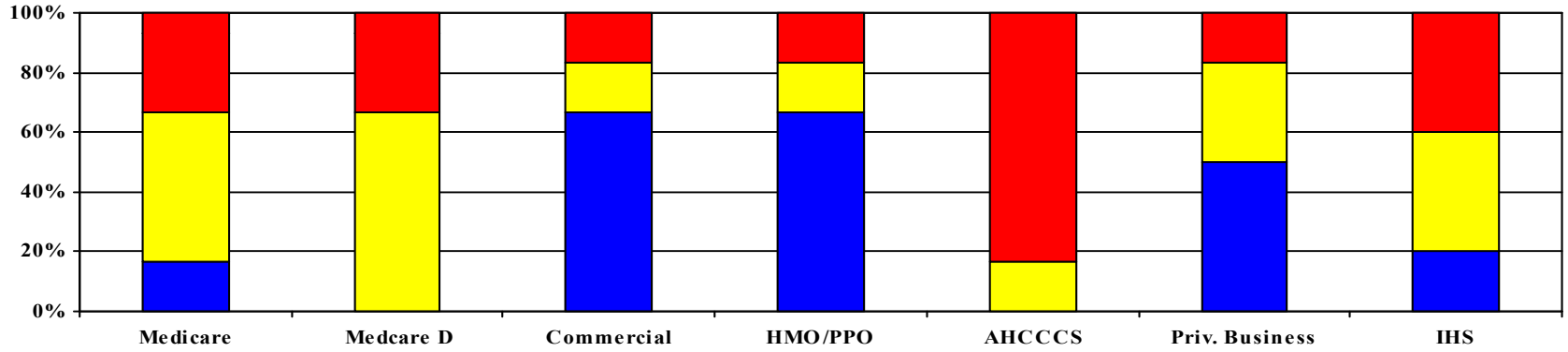


How do you rate the following payors for hospital services?

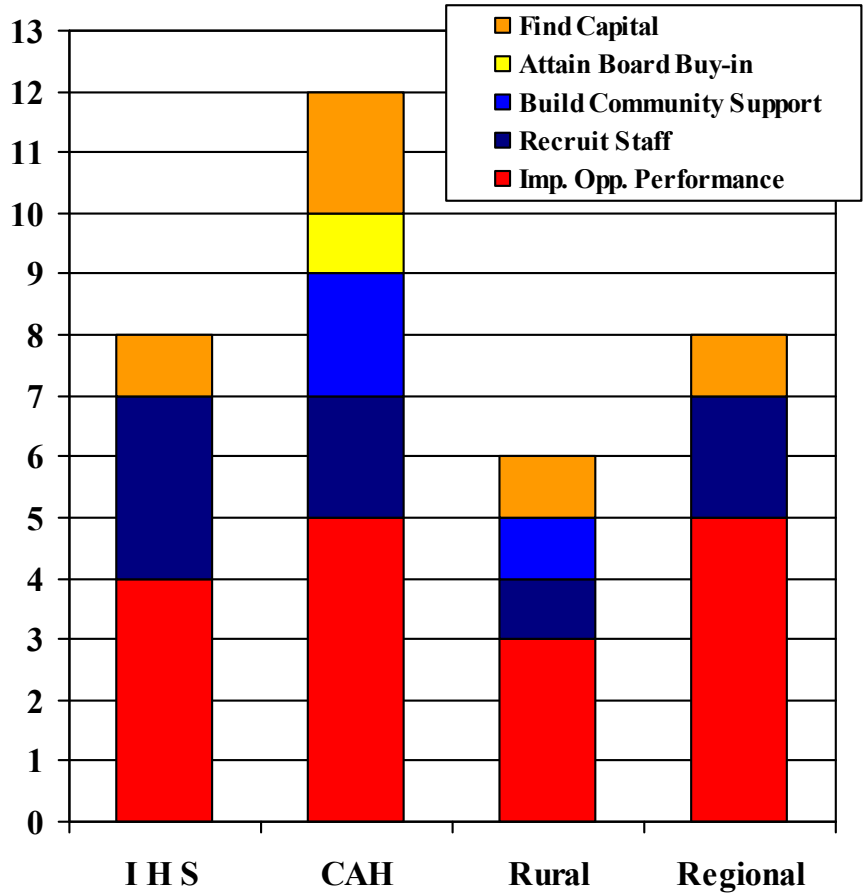
Rural



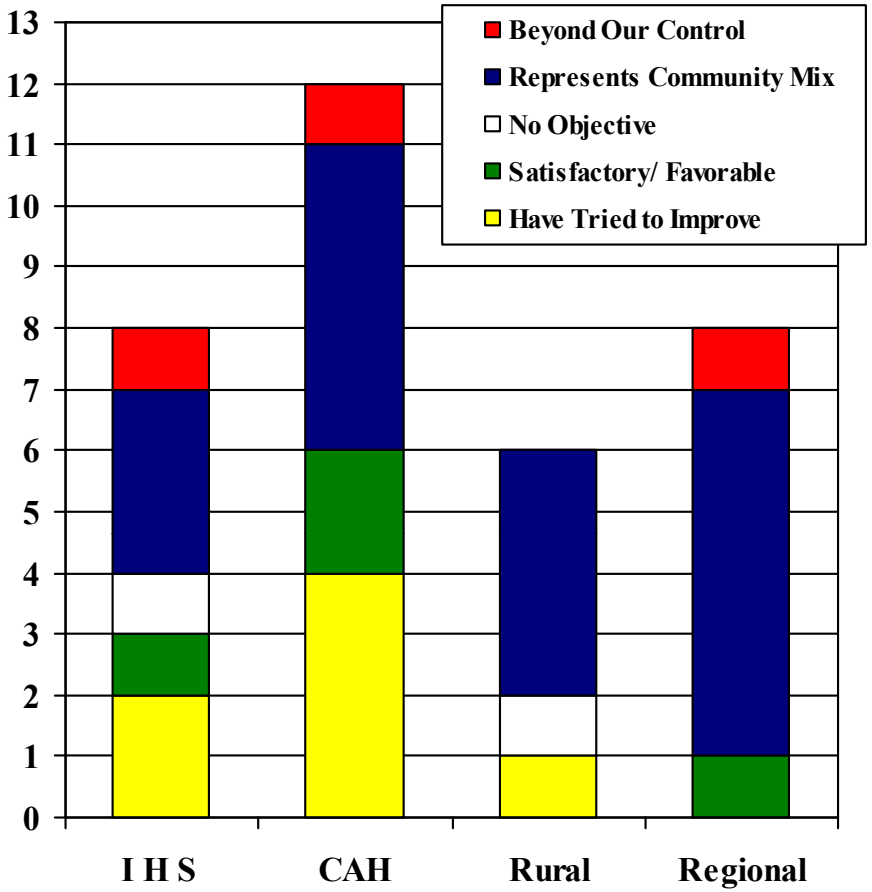
Regional



What is your highest priority in hospital development?



Which ***one*** statement (in general) best represents your payor mix perspective?



What is the one most important thing that the Arizona Legislature can do to facilitate:

Hospital Development (32)

- Support and Increase AHCCCS payments (N=16)
  - to CAHs (2)
  - Preserve reimbursement Rate adjustments for Rural Hospitals that don't benefit from economies of scale
  - Support funding for unreimbursed care and 1011 program (2)
- Workforce Development(5)
  - Provide more Educational Support for Physician, Nurse, and Ancillary students
  - Tort Reform
- Improve Congressional Funding (5)
- Grant funding for Technology/EMR (2)
- Abstain from mandating reimbursement in Health Care sector (eg. Healthcare Group, Health Plan of Arizona) (2)
- Support Arizona Health Facilities Authority
- Ease regulations on Hospital Districts

Improved Healthcare (32)

- Workforce Development (N=14)
  - Provide incentives for Physicians to move and live in rural Arizona (6)
  - More Educational Support for Physician, Nurse, and Ancillary students (GME, Nursing / Alied Health Programs)(2)
  - Tort Reform
- Preserve and Increase AHCCCS funding (N=11)
  - to CAHs (2)
  - Equitably Fund AHCCCS and DSH
  - Support funding for Unreimbursed costs and 1011 program
- Financially supporting access to capital for technology adoption in primary care delivery (3)
- Support statewide initiatives and collaborations that support improved healthcare and provide incentives to reward and encourage wellness vs "sickness" model (2)
- Support Arizona Health Facilities Authority
- Require State and County health programs to recognize responsibility for tribal communities

How much do you plan/estimate on spending over the next 5 years on the following:

CAHs

- Hospital Facility
  - Less than $1m 2
  - $1m - $5m 3
  - $5m - $10m 2
  - $10m - $20m 2
  - $20m -$30m 1
  - More than $20m 1
- Other Facility
  - Less than $1m 5
  - $1m - $5m 6
  - $5m - $10m -
  - $10m - $20m -
  - $20m -$30m 1
  - More than $20m -
- Equipment
  - Less than $50k 1
  - $50k - $100k -
  - $100k - $500k 3
  - $500k - $1m 2
  - $1m -$5m 4
  - More than $5m 1
- Subtotal **$114m+ - $246m+**

Rural

- Hospital Facility
  - Less than $1m -
  - $1m - $5m 1
  - $5m - $10m -
  - $10m - $20m 2
  - $20m -$30m 1
  - More than $20m 2
- Other Facility
  - Less than $1m 2
  - $1m - $5m 1
  - $5m - $10m 1
  - $10m - $20m -
  - $20m -$30m -
  - More than $20m 1
- Equipment
  - Less than $50k -
  - $50k - $100k -
  - $100k - $500k -
  - $500k - $1m -
  - $1m -$5m 2
  - More than $5m 3
- Subtotal **$125m+ - $252+**

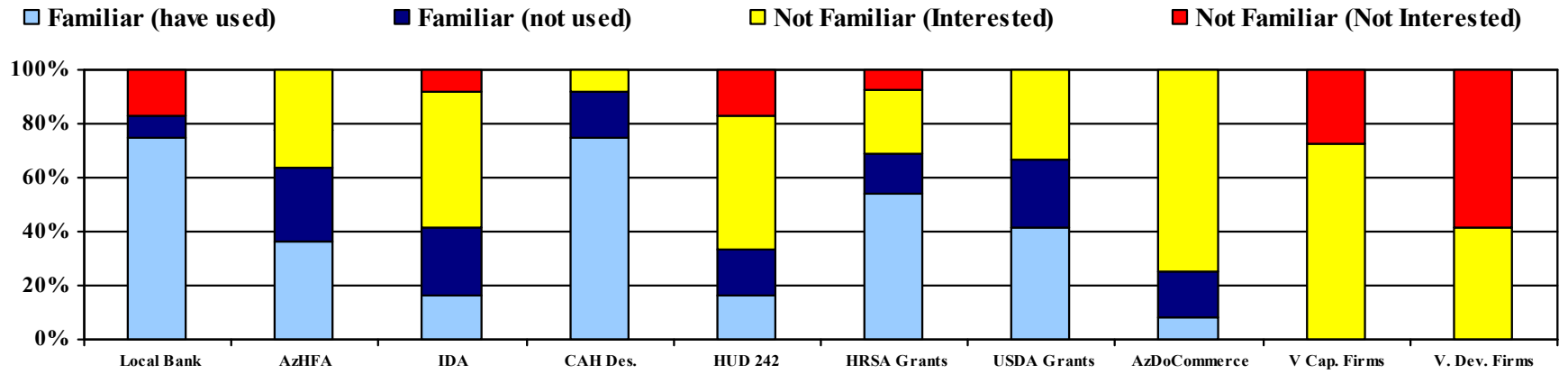
Regional

- Hospital Facility
  - Less than $1m -
  - $1m - $5m -
  - $5m - $10m -
  - $10m - $20m 5
  - $20m -$30m 1
  - More than $20m 2
- Other Facility
  - Less than $1m 2
  - $1m - $5m 1
  - $5m - $10m 1
  - $10m - $20m 3
  - $20m -$30m -
  - More than $20m -
- Equipment
  - Less than $50k -
  - $50k - $100k -
  - $100k - $500k -
  - $500k - $1m -
  - $1m -$5m 2
  - More than $5m 5
- Subtotal **$172m+ - $347m+**

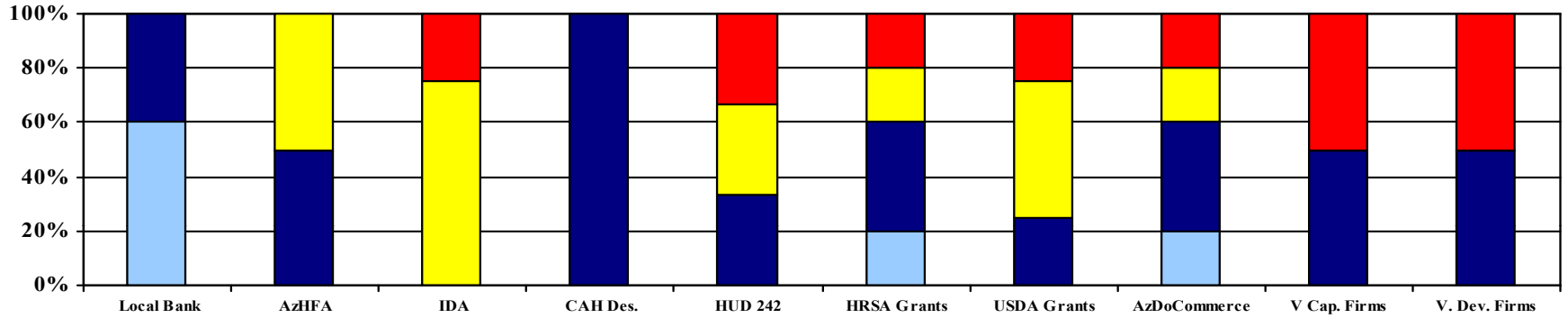
Appendix O – Survey Question 9b

What is your familiarity with the following entities/resources?

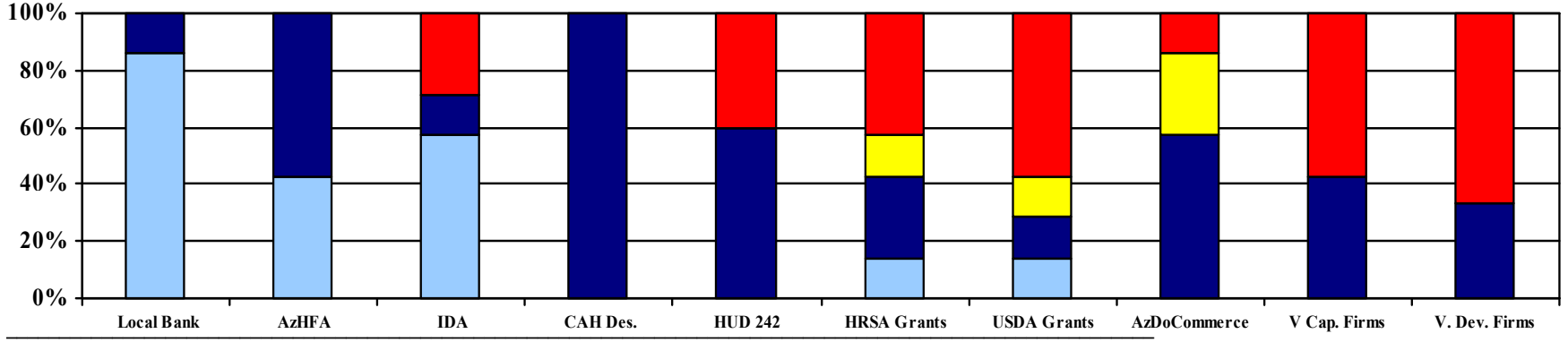
CAHs



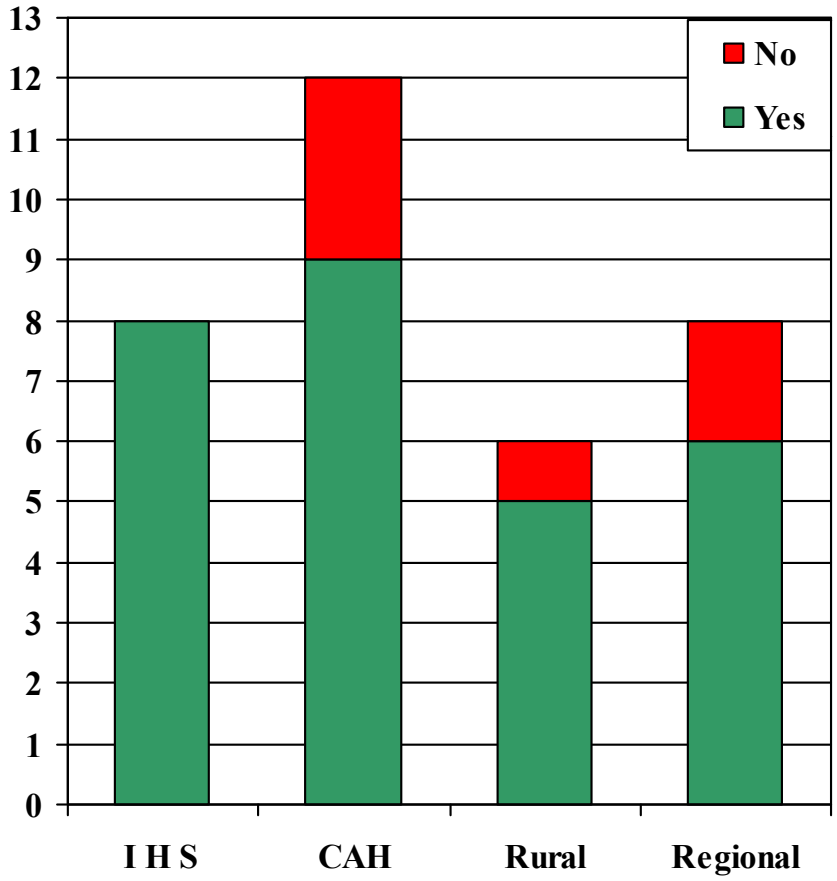
Rural



Regional



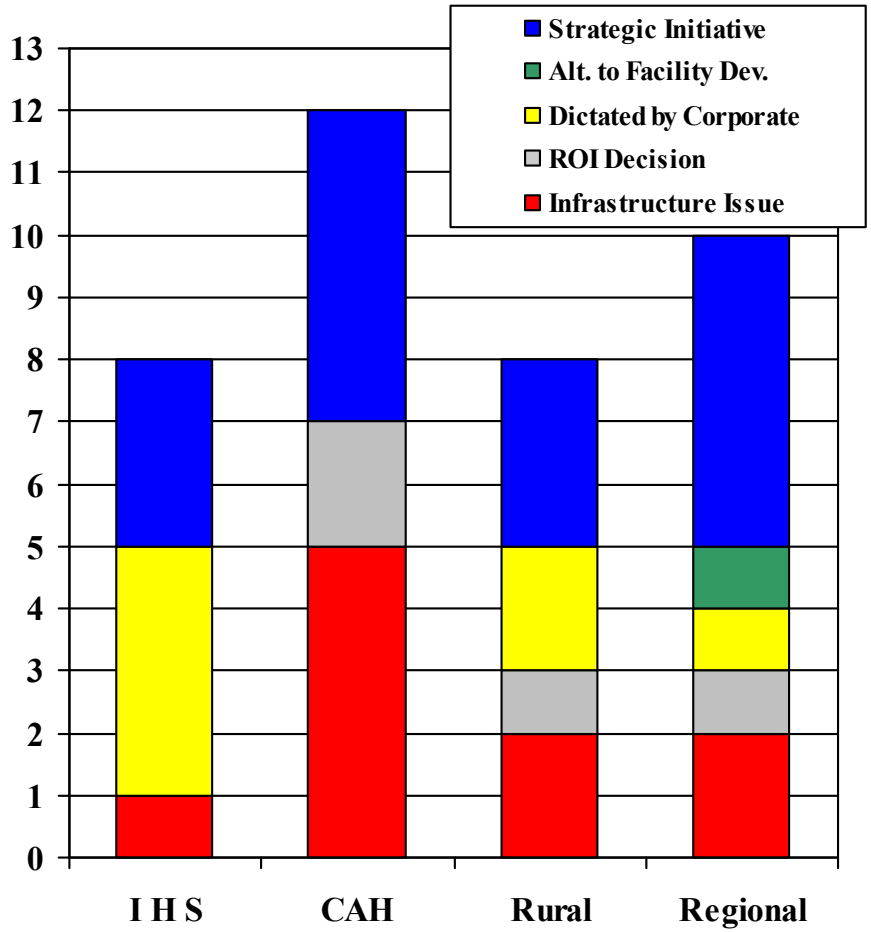
Has your hospital implemented any Electronic Health Record System internally?



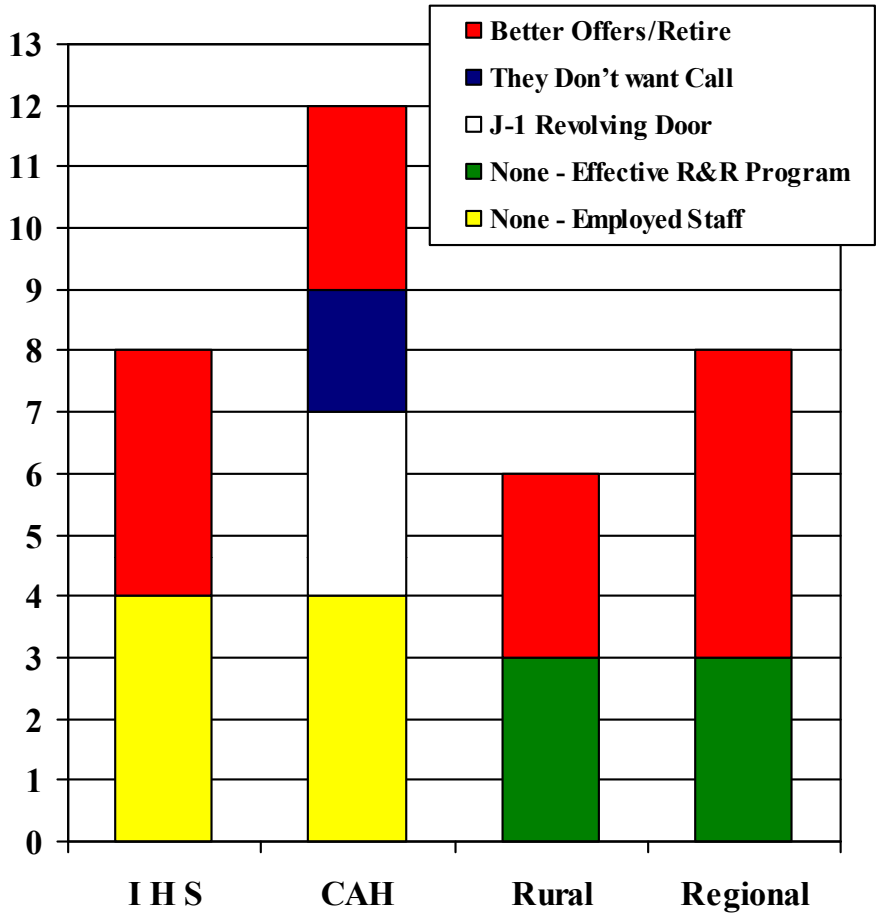
- Yes – *please explain*
  - Lab, Pharm, Clinic (4)
  - X-Ray, Rad, CPSI (3)
  - Paperless clinics (2)
  - Inpat. M/S, OB, ICU
  - Fully Implemented
  - Next Gen
  - ER

- No – *what plans are in place to implement an EMR?*
  - None, Not determined (2)
  - Complete by 2010
  - Approximately 50% complete
  - Upgrade Meditech
  - Full EMR
  - System selection complete

Which dominant phrases best describes the role technology plays in your hospital?

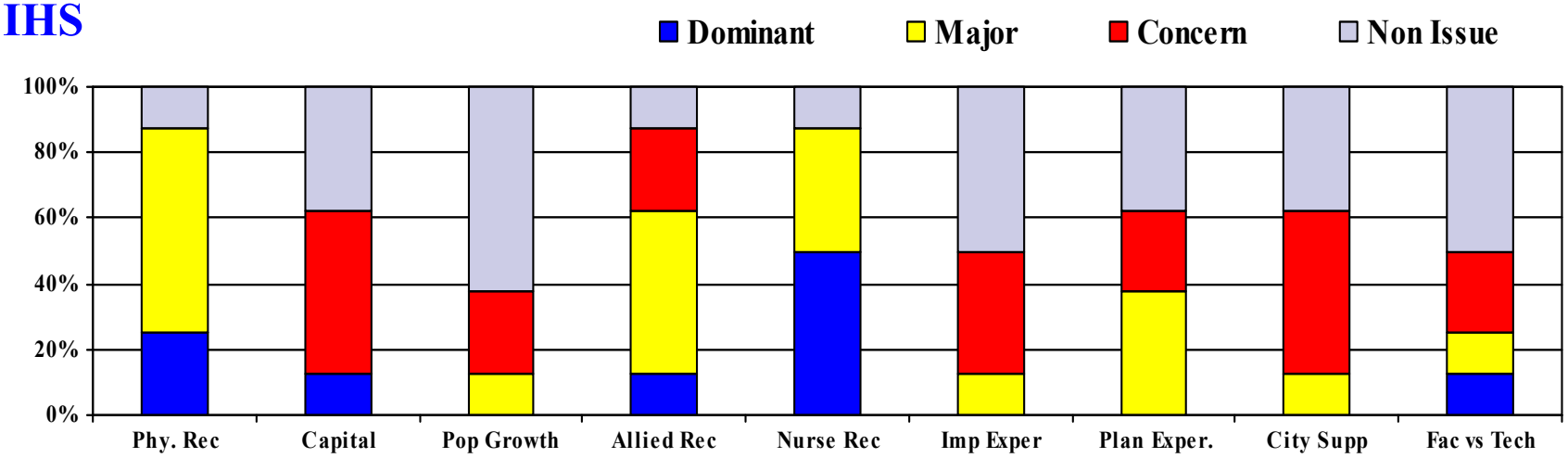


Which best describes your admitting physician staff turnover?

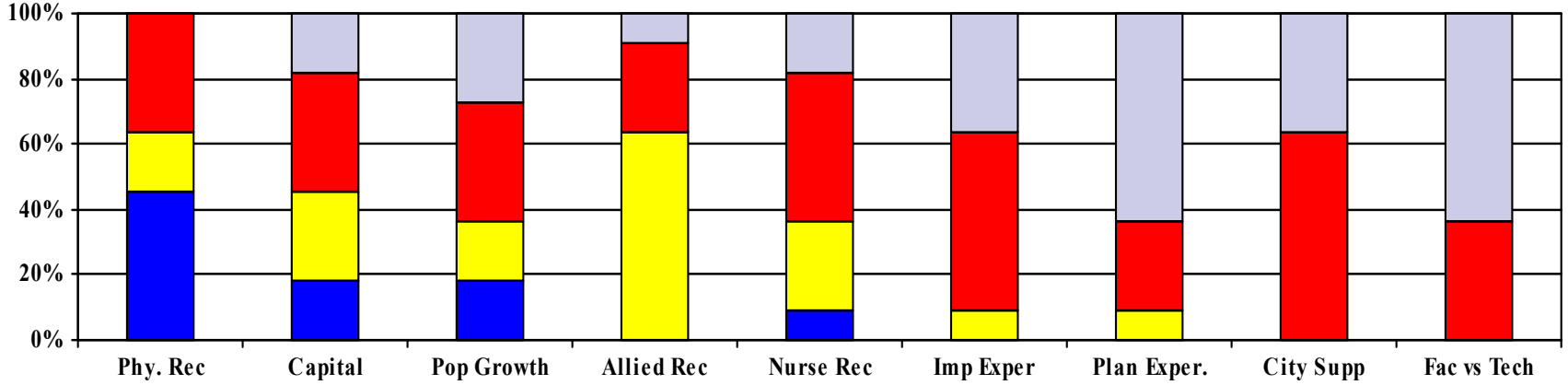


Rank each issue regarding your hospital facility development efforts:

IHS

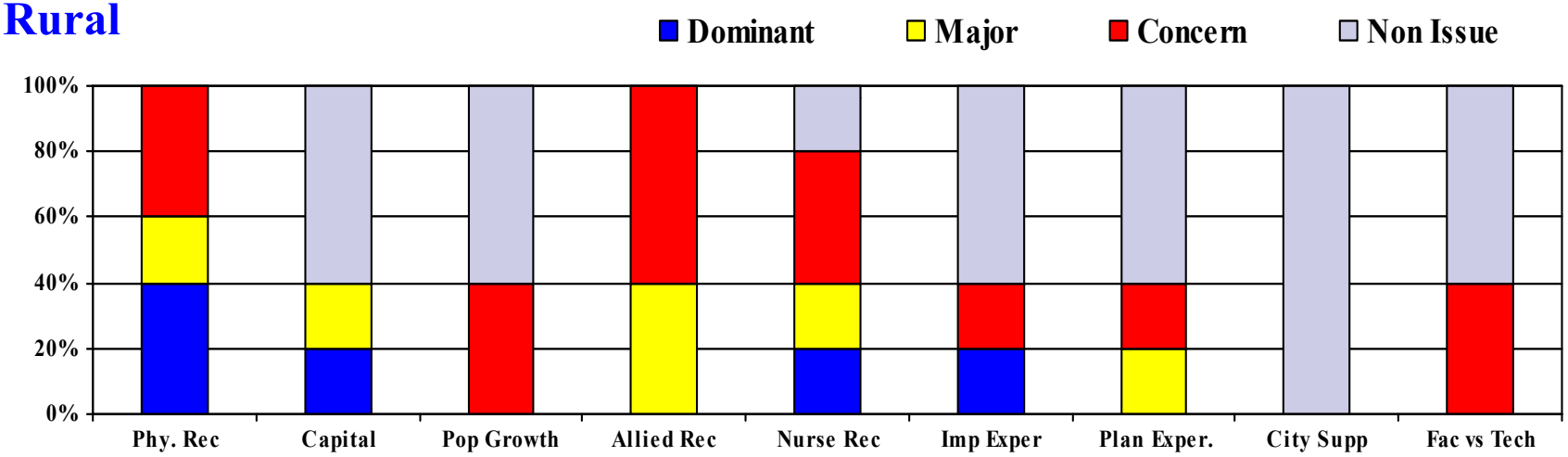


CAHs

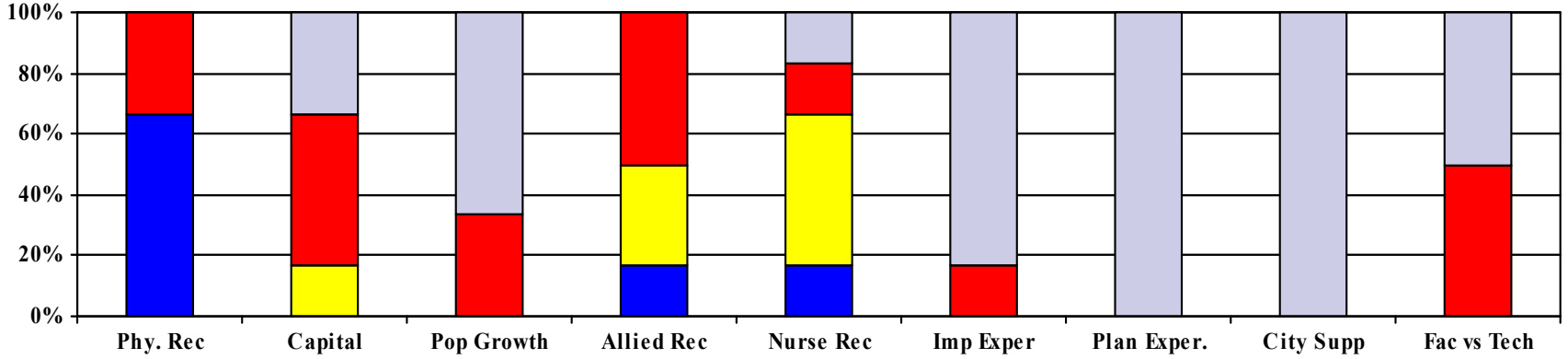


Rank each issue regarding your hospital facility development efforts:

Rural



Regional



Raymond P. Cooke, P.E.
DHHS/IHS - Deputy Director
Division of Facilities Planning & Construction
Office of Environmental Health & Engineering

IHS Health Care Facilities FY 2009 Planned Construction Budget ($000)

Arizona Facilities

				2009 5 Year Plan						
			Cumulative to date	2007	2008	2009	2010	2011	2012	Out years	Total cost
Inpatient	AZ	PIMC Hosp System	224	-	-	(1,000)	-	-	-	-	(1,224)
		SE ACC	2,590	-	-	(29,120)	(29,120)	-	-	-	(60,830)
		SW ACC	9,236	(17,664)	-	-	-	-	-	-	(26,900)
		NE ACC	-	-	-	(4,110)	(28,065)	(28,065)	-	-	(60,240)
		Central Hosp & ACC	-	-	-	-	-	-	-	(524,498)	(524,498)
	AZ	Whiteriver Hosp	-	-	-	-	(11,076)	(37,883)	(49,915)	(91,831)	(190,705)
Outpatient	AZ	Ft Yuma HC 89-96	-	-	-	(2,163)	(29,392)	-	-	-	(31,555)
	AZ	Kayenta HC	4,318	(2,000)	-	(43,320)	(43,320)	(43,319)	-	-	(136,277)
	AZ	San Carlos	6,604	(2,000)	-	(42,064)	(42,065)	(18,000)	-	-	(110,733)
	AZ	Winslow Dilkon	-	-	-	-	(6,126)	(33,851)	(33,851)	(33,850)	(107,678)
Joint Venture	AZ+	Health Centers (5)	14,722	(2,639)	-	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)	-
Joint Venture	AZ+	Small Health Clinics (9)	36,773	-	-	(10,000)	(10,000)	(10,000)	(10,000)	(10,000)	-
Joint Venture	AZ+	Dental	13,434	-	-	(3,000)	(3,000)	(3,000)	(3,000)	-	-